ACCESS TO MENTAL HEALTH CARE AND TRAUMATIC BRAIN INJURY SERVICES: ADDRESSING THE CHALLENGES AND BARRIERS FOR VETERANS

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATION

OF THE

COMMITTEE ON VETERANS' AFFAIRS

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ACCESS TO MENTAL HEALTH CARE AND TRAUMATIC BRAIN INJURY SERVICES: ADDRESSING THE CHALLENGES AND BARRIERS FOR VETERANS

Thursday, April 24, 2014

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, D.C.

The subcommittee met, pursuant to notice, at 1:00 p.m., in Southern Arizona VA Health Care System, Conference Room B, 3601 South Sixth Avenue, Hon. Mike Coffman [chairman of the subcommittee] presiding.

Present: Representatives Coffman and Kirkpatrick.

Also Present: Representative Sinema.

OPENING STATEMENT OF CHAIRMAN MIKE COFFMAN

Mr. COFFMAN. Good morning. This hearing will come to order.

I want to welcome everyone to today's hearing titled "Access to Mental Health Care and Traumatic Brain Injury Services: Addressing the Challenges and Barriers to Veterans."

I would also like to ask unanimous consent that Representative Sinema of Arizona be allowed to join us here on the dais to address the issues before us today.

Hearing no objection, so ordered.

Providing the necessary care and treatment for traumatic brain injury has to be among the highest priorities of the Department of Veterans' Affairs. The nation's returning soldiers who have survived devastating blasts from improvised explosive devices and ordnance deserve the best possible medical care for their injuries that this nation can offer.

They also deserve compensation for the disabilities connected to their military service. Given the prevalence of TBI among the veterans of Operation Enduring Freedom and Operation Iraqi Freedom, all veterans receiving medical care at VA are required to undergo screening for it. According to the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, more than 287,000 service members have sustained traumatic brain injury between 2000 and the third quarter of 2013. Almost 80 percent of these injuries were classified as mild TBI. According to Dr. Robert Petzel, Undersecretary of Health, there has been an almost 70 percent decline in the number of severe TBI cases in recent years, while the number of mild to moderate cases has increased.

He said, "It costs much less to treat that group than the polytrauma cases." As a result, the Administration's budget request for Fiscal Year 2015 is for $229 million for TBI medical programs, down nearly 1.3 percent from Fiscal Year 2014.

Today, we will hear from veterans and their families about the serious long-term consequences of traumatic brain injury. We will hear about the continued challenges veterans have to getting access to necessary services for TBI. Even with mild TBI, which constitutes the great majority of cases, VA is failing to provide proper screening and may be undercompensating veterans with very real disabilities.

Today, Captain Charles Gatlin and his wife, Ariana Del Negro, will testify about the traumatic brain injury Gatlin suffered in an IED blast and about their subsequent struggles with VA. When Captain Gatlin was medically discharged from the Army, he had a 70 percent disability rating from the Department of Defense. Notwithstanding the fact that Captain Gatlin had already undergone three comprehensive neuro-psychological tests by doctors at the Department of Defense that indicated mild TBI, Captain Gatlin was subjected to a perfunctory test by a psychologist at VA when he moved to Fort Harris in Montana in 2009. As a result of this test, Captain Gatlin received a rating of only 10 percent disability by the VA. Significantly, the psychologist who administered the VA screening has been brought up on adverse licensing charges by the Board of Psychologists for the State of Montana. The Board has reasonable cause to believe that the VA psychologist misused a diagnostic test and failed to conduct his assessment in accordance with the applicable standard of care.

The VA has enlisted the Department of Justice to defend the psychologist on the grounds that state licensing laws are preempted. Essentially, the Department of Justice is arguing that VA can use unqualified personnel and substandard tests at its discretion in disability determinations.

Substandard sampling for TBI research apparently is also a problem at VA. According to a recent study, only 5.4 percent of eligible veterans participated in responding to VA's Markers for the Identification of Norming and Differentiation of TBI and PTSD. The MIND study is what it was called. The poor response rates cast significant doubt that the $3 to $4 million in taxpayer money on the MIND study over the past five years was well spent.

I want to thank all the witnesses for appearing at this hearing today. Your testimony is important and in the end will lead to more consistent, comprehensive, and compassionate care for our nation's veterans. It is our job to see that we get it right and we do not fail those who have sacrificed so much for this country.

With that, I now recognize Ranking Member Kirkpatrick for opening statements.

OPENING STATEMENT OF ANN KIRKPATRICK, RANKING MEMBER

Mrs. KIRKPATRICK. Thank you, Mr. Chairman and Congresswoman Sinema, for being here today for the veterans and their families in District 1 in Arizona and across the country.

I would also like to acknowledge that our colleagues, Congressman Barber, Grijalva and Gosar, have members of their staff here today. They are in Yuma for the dedication of the John Roll United States Courthouse.

I also thank all of you who are here today, whether to participate or to observe. Your presence is greatly appreciated.

As members of the Oversight Investigations Subcommittee and as members of Congress, we have a duty to stand up for our veterans. It is our job to fight for those who have served. I called for today's hearing because ensuring access to timely, safe, quality health care for our veterans is one of my top priorities. We need to examine the connection between TBI and PTS and access to care.

Many of us are aware of the troubling reports about the Phoenix VA Medical Center and the patient deaths allegedly caused by long wait times for an appointment or consult. While we don't have all of the facts, we do know that delayed care is denied care. And I have already called for a hearing on this after the Inspector General's investigation is completed.

I am deeply concerned that lengthy appointment wait times in the VA system may be discouraging veterans from seeking help when they need it most. With TBI being the signature injury of the Iraq and Afghanistan wars, we know that having a traumatic brain injury can amplify the symptoms of PTS. Many of our veterans suffered TBIs, and they also suffer from PTS. Their needs need to be sustained and they need quality care for the rest of their lives.

In Arizona, many of these veterans live in rural areas, including our Native American veterans. These men and women need the same care and the same services as veterans in urban areas near large VA medical facilities like Tucson.

The VA health care system must be able to provide timely, high-quality care to the veterans who are already in the VA system and be ready for the expected increase in the number of veterans who will soon become part of the VA system.

This hearing will focus on how VA is addressing the needs of our veterans who have sustained traumatic brain injuries and suffer from mental health conditions. From this hearing, I hope to identify where improvements by the VA are needed and to identify some best practices and resources to care for our veterans. I hope this feedback can help break down barriers for access to mental health services.

The Tucson VA is one of 23 polytrauma network sites, and I look forward to hearing from our panelists from the Southern Arizona VA Medical Health System on how they are providing treatment for our veterans with TBI and PTS.

I also want to thank our first panel for sharing your stories with us. I know it must be difficult, but hearing from you allows me and this subcommittee to better understand the challenges and barriers to proper care. I, along with the subcommittee, continue to hear stories of many struggles veterans face when trying to access VA mental health and TBI services. Whether it is a delay in care, a denial of care, or care is just not available, frustration with the system may lead to the veteran foregoing needed care altogether, which is unacceptable and can lead to crisis.

I look forward to hearing from our panelists today and have a productive discussion on these very important issues.

Thank you, Mr. Chairman. I yield back.

Mr. COFFMAN. Thank you, Ranking Member Kirkpatrick.

With that, we have the first panel at the witness table. On this panel we will hear from Mr. Derek Duplisea, Regional Alumni Director of the Wounded Warrior Project; Captain Charles Gatlin, United States Army, retired, and his wife, Ariana Del Negro, Co-Founder of Veterans Leadership Assistance.

I would now like to allow Ranking Member Kirkpatrick to introduce the remaining witnesses on our first panel.

Mrs. KIRKPATRICK. Thank you, Mr. Chairman.

It is my pleasure to introduce a few members from our first panel.

Mr. David Anderson is a veteran and the Post Commander at the American Legion. David is also Native American, and we are very interested in hearing your perspective. Thank you for being here.

Mr. Jerry Boales, also a veteran, is Chairman of the Rock Soldiers for Wounded Warriors. He just had surgery, and this committee meeting was so important to him that he made it here today. Thank you very much.

Mr. John Davison is a dear friend of mine from Flagstaff, father of a wounded warrior who just committed suicide, and I spoke at the funeral service. This is tough for me and for John and his family, so there may be some tears.

Then I would like to introduce Brad Hazell. Brad is also a veteran, and Brad worked in my congressional office in Casa Grande, has a stunning reputation for helping our veterans, and we look forward to your testimony.

Thank you.

Mr. COFFMAN. Each of your complete written statements will be made part of the hearing record.

Mr. Duplisea, you are now recognized for 5 minutes.

STATEMENT OF DEREK DUPLISEA

Mr. DUPLISEA. Chairman Coffman and Ranking Member Kirkpatrick, thank you for inviting Wounded Warrior Project to testify on behalf of both the professional and personal concern for me. In 2006, in August, right before my second deployment to Iraq was to end, a suicide bomber left me severely wounded, effectively ending my 13-year U.S. Army career as a cavalryman, airborne-armor paratrooper, and scout. I spent the next two years recovering from injuries that included a severe penetrating traumatic brain injury, a shattered right femur, a completely shattered right arm that was nearly amputated, burns, nerve damage, and PTSD. I've been working with and on behalf of wounded warriors since a few months after I medically retired from the U.S. Army in 2008.

I am proud to serve as the Western Regional Director for Wounded Warrior Project's Warrior Engagement Programs. In addition to operating 20 direct-service programs for almost 50,000 warriors with whom we work, Wounded Warrior Project conducts an annual survey. Our most recent survey found that three most common reported health problems among our warriors are PTSD at 75 per-

cent, anxiety at 74 percent, and depression at 69 percent. More than 44 have experienced a TBI.

The survey shows that for many, the effects of mental and emotional health problems are even more serious than the effects of physical problems, with more than 25 percent in poor health as a result of a severe mental health condition.

On mental health care, access to mental health care is clearly vital, but access alone isn't enough. Care must also be both timely and effective. We see wide variability in VA mental health care from facility to facility. My own experience at the Tucson VA has been very positive, but many other facilities still seem to lack enough mental health staff despite VA adding some 1,300 new mental health professionals.

VA has also put a new emphasis on scheduling new mental health appointments within 14 days, but there is also a big difference between being seen for an initial assessment and actually starting treatment, which may not occur for weeks or months, leaving some veterans feeling desperate.

Despite the hard work of dedicated, professional clinicians at many VA facilities, we still see evidence of a system that is understaffed and under stress. Here are some examples we see around the country.

Veterans who need individual therapy are frequently being pushed into group therapy or taking the group option because the wait time for the individual treatment is too long. Some rural VA clinics are placing veterans who have depression or anxiety on waiting lists or not providing them treatment at all to give priority to those with combat-related PTSD. A large number of warriors are reaching out to our organization for help in finding mental health treatment options because of VA timeliness issues.

VA facilities can seldom provide treatment proactively as needed and instead can only react when the veteran's condition deteriorates to a point of crisis. And, as we learned from a recent survey, of those who sought VA care for military sexual trauma-related conditions, 49 percent reported difficulty accessing that care.

We don't suggest that these are simple problems, but it is not good enough to say that the VA has seen a high percentage of veterans when treatment is often sporadic or limited to providing medications. Access to timely, effective treatment should be the norm, not simply a distant goal.

Regarding traumatic brain injury, we are particularly concerned about VA's failure to implement bipartisan legislation Congress enacted in 2012. That law was aimed at providing long-term rehabilitation of veterans with TBI, and it calls for VA to apply a new model of TBI rehabilitation. Under the law, rehab services are not to be cut off based on the view that the patient has plateaued. The law also directs VA to provide any community-based services or support that might contribute to maximizing the veteran's independence.

The point is that rehab services should not end when the veteran returns home. For many, the rehab journey only starts then. But we see no evidence that the VA has implemented this law or that it had any effect on VA practice. It remains common for warriors to have TBI rehab services discontinued after a set number of

treatment sessions or based on the view that the warrior has plateaued. Families report that they are left to their own devices to continue the warrior's rehabilitation. The upshot is that 25 percent are paying out-of-pocket for services VA is not providing. One-quarter of those pay more than $300 monthly out-of-pocket to provide rehabilitative services.

The Wounded Warrior Project is not just complaining. We have established a program of our own, providing 140 warriors with severe TBI the very kind of community support the VA should be providing. We will be expanding the program to help more warriors, but we also want VA to implement the TBI law and urge the subcommittee to press that point back in DC.

Finally, we look forward to working with you here in Arizona and the nation's capital to improve the care of veterans with mental health needs and those with TBI. In the Army, we were always taught to have faith in our equipment. My helmet here today testifies to that faith. If I was not wearing this helmet, I would not be here today. We now put our faith as warriors and veterans in you, the government and the VA.

Thank you.

[THE PREPARED STATEMENT OF DEREK DUPLISEA APPEARS IN THE APPENDIX]

Mr. COFFMAN. Thank you, Mr. Duplisea, and thank you so much for your service. I come from a Colorado military family. I am a congressman from Colorado, and my father was a World War II veteran. I was in the first Gulf War and Iraq War.

Mr. DUPLISEA. Thank you.

Mr. COFFMAN. Thank you.

Ms. Del Negro and Captain Gatlin, you are now recognized for 5 minutes.

STATEMENT OF ARIANA DEL NEGRO

Ms. DEL NEGRO. Thank you, Mr. Chairman, Ranking Member Kirkpatrick. My name is Ariana Del Negro, and my husband, Captain Charles Gatlin, and I would like to formally submit our written testimony for the record.

We are here today to voice our profound concerns regarding the VA's handling of C&P claims for residuals of traumatic brain injury and unethical practices not only at the Fort Harrison VA in Helena, Montana, but potentially across all VA systems. The consequences are far-reaching. The emotional, physical, and financial tolls placed upon the veterans and their families in seeking to right wrongs in the system is unacceptable and warrants immediate corrective action.

As Chairman Coffman mentioned, my husband, whose scout recon platoon was retired from the Army in 2009 having received a 70 percent rating for his traumatic brain injury, which starkly contrasted with the Montana VA, who gave him a 10 percent. The discrepancy between the DoD's rating and the VA's rating and the failure in accountability of the latter are the basis of our concerns with the VA. The lower rating assigned was a consequence of the fact that the examiner, a clinical psychologist, was not licensed to conduct neuropsychological testing. The test he used was a screen-

ing measure for dementia, not TBI, and he misinterpreted the results, thus providing C&P raters medically inaccurate information on which to base their disability rating.

As my husband will attest to next, our efforts to rectify this straightforward matter have been met with hostility and stonewalling from weak leadership. What will it take for a system to be held accountable, where the interests of the veteran are placed before the bureaucracy of the system?

[THE PREPAPERD STATEMENTS OF ARIANA DEL NEGRO & CHARLES R. GALTIN APPEARS IN THE APPENDIX]

STATEMENT OF CAPTAIN CHARLES GATLIN

Captain GATLIN. This stands as a Ranger creed: "Never shall I fail my comrades. I will keep myself fit and alert, physically strong, and morally straight, and I will shoulder more than my share of the task, whatever it may be, 100 percent, and then some." The VA needs to learn that.

Good afternoon, Honorable Chairman and Ranking Member Kirkpatrick. My name is Captain Charles Gatlin, and I thank you very much for the opportunity to participate and discuss an epidemic of dynamic proportions that has manifested within my State of Montana, the recently dysfunctional nature and incompetence of the Fort Harrison VA, VHA and VBA.

I would like to submit my oral testimony annotating my unequivocal level of frustration with fraud, waste and abuse with respect to TBI systems operation and associated personal and professional misconduct of the Montana VA.

The VA in Montana is experiencing problems with respect to accountability and patient care. While I realize that no one system is perfect, at what point do senior echelon staff and officials choose to ignore, even mitigate, major concerns brought to their attention by qualified veterans? To neglect these forces of action, which could be construed as the equivalent of fraud, waste and abuse to the veteran, and will only cost the American taxpayer a tidy sum, to place an additional social and emotional burden on our nation's returning wounded, their families, and particularly those with varying levels of TBI and other injuries.

Montana has a very challenging geography that already makes sustained access to care difficult. But to compound these issues with gross incompetence, neglect, and cutting corners is a tremendous disservice to our veterans perpetrated by staff at Fort Harrison and other regional offices.

Ladies and gentlemen, this needs to be corrected, and this needs to be corrected immediately.

To bring attention to the severity of the potential criminal nature of these acts, I will briefly highlight several observations within the Montana, Salt Lake, Denver VA offices and how their collusive interactions have led me to be sitting here before you today.

Within the Montana VA, physicians are knowingly operating outside the scope of their licenses, which results in intentional and systematic lowering of the quality care and disability ratings. As an example, one such clinician, Robert J. Bateen, Ph.D., made clinical conclusions outside the scope of his expertise. In the eyes of the

VA, this is acceptable. However, he was in violation of several tenets of his license by his peers at the Montana State Board of Psychologists.

When Dr. Trena Bonde, the Medical Chief of Staff, was approached with this objective and factual information, along with a request for formal and informal reviews, the veteran, myself, was referred to a VA attorney. I ask you, is this how we treat wounded vets? Substandard care and the argument that the VA is immune to state oversight, ethics, and administrative policies? Sadly, this type of behavior and disregard for patients and veterans are common occurrences within the Fort Harrison system. When veterans must be proactive and seek administrative recourse to correct injustices, they are ignored and told they are attacking the VA.

When I asked to see an M.D. to administer a proper diagnosis, why am I referred to a VA regional counsel, Jeff Stacy? When veterans seek recourse through varying levels of leadership and appointed directorships such as Willy Clark and John Skelly, why are they referred to legal counsel? All of which, I might add, are in direct violation of internal VA policy, Federal code, and rules set forth by the Office of Regulation and Policy Management.

When I speak with regional counsel to seek clarification and get a conference call between the VBA and the VHA to figure out what is going on, I am told I am disingenuous and faking my injury. Is this how the system operates?

For all intents and purposes, I have just outlined fraud, waste, and abuse on the individual level, and there remains no accountability.

I bring this up in hope of clarifying my position with this epidemic that is going on.

Now consider this, and I will be very brief. Montana has the second-highest VA population in the United States, roughly 10 percent. Couple that with a very unique population distribution and challenging geography and you will see why the transparent accountability with respect to resources and care become evident.

Thank you, Chairman, esteemed members of the committee, for the opportunity to speak on behalf of not only service men and women in uniform but retirees, honorably discharged vets, concerned citizens, and most especially caregivers.

Thank you for your time.

Mr. COFFMAN. Thank you both. And, Captain Gatlin, thank you again for your service.

Mr. Anderson, you are now recognized for 5 minutes.

STATEMENT OF DAVID ANDERSON

Mr. ANDERSON. Thank you, Mr. Chairman and members of the committee. My name is David Anderson. I am from Akimel O'odham Tribe, better known as Gila River Indian Community. I am a 20-year veteran. I am also an American Legion Post Commander within the Gila River Indian Community. I am also a Founder and Chairperson for O'odham veterans. Native Americans as a whole are the largest minority in the Armed Forces, but we are the least amount in utilizing our VA benefits.

Now, saying that, the VA does help us out. I mean, they have come a long way in the last 10 years. But people like Phyllis

Spears here in the Tucson VA, Mike Leone in the Phoenix office have helped me tremendously over the last four years trying to get Native Americans signed up for veterans benefits.

I am saying that also there are—I don't want to say there are only problems there because there are good people here in the VA. So I would like to say that.

Like I said, I received a TBI in 1987 when nobody knew what a TBI was. I got promoted to E7 in seven years. I was at the top of the Army, 1 percent of the Army on my career progression. But after I got a TBI, I was on every urinalysis. Everybody didn't know what was going on. Everybody was, like, "Oh, he's on drugs." When you go to that super-soldier and you are on that downward spiral, people didn't know, and I am glad that we are looking at this to help our veterans.

But in saying that, 22 veterans die every day in the United States. We are more suicides than what we have lost in Afghanistan and Iraq, which is a sad thing to say.

When I got out in 2000, I started through the VA process in 2003. Going through that process with my mental health caregiver, right off the bat the VA wants to give you drugs instead of dealing with the situation. I was sleeping 18 hours a day, and when I was told, I said I don't want to sleep 18 hours a day, I am getting more depressed, I feel like I am falling off what I already had, you know? And their comments to me were, well, either take these drugs or we are done here.

Of course, I had PTSD, TBI, and I said, okay, I guess we are done here, you know? And through my faith and my tribe and other veterans, I fought that and fought that, and somewhat recovered. From alcoholism to fighting with the police, getting thrown in jail, I went through that whole gambit of troubles that we see our young veterans going through.

I counsel young veterans on a daily basis, and I see the problems that we are having. I have one veteran who said he had talked about hurting himself, so he got a one-way trip to here. They took him off the gurney, strapped him down and gave him drugs, pushed him in a room with 12 other people.

There is no crisis management within the VA to deal with these situations, and I guess that is my whole deal. PTSD is not a new disease or a new anything within the U.S. services. I mean, our Native tribes, when we went away to battle, we could not come back to the village for three to five days until you got cleansed, until you got all of this out. It is nothing new, but the VA does not cure people. They medicate people.

That is where we need to look at our professional services and to get away from those drugs and to really deal with the problem here, and that is what I am here to say. We need to out-source those problems.

I am trying to get an MOU with our tribal hospital and the VA, which the VA in pamphlets has said, oh, yes, this is the best thing since sliced white bread. But they only want to pay for in-source kind. All tribal hospitals are small in size. We out-source things. We don't have a cardiologist. We don't have a bone specialist. We out-source them. But the VA is still not willing to pay for those outsourcings.

We don't have the time, like these people are saying, to get these people proper medical treatment without the out-sourcing. We can't send them to the VA because they will never be seen, and that is why we are looking to out-source them, our Native American veterans, to get the proper treatment.

I guess I would look at this committee for help on that because, as veterans, like I said, we are the largest minority in the Armed Forces, and this is what we need, is to be able to out-source and to help our veterans. As we all know, most Native American communities are alcohol and drug abuse, which is not helping our veterans. But I think if we are allowed to out-source them to get them the proper treatment, then as Native Americans go, I think we would be a lot better off than trying to send them to a veterans hospital where there is no help. They are over-burdened. They are over-booked.

I come from the Grande Office. We have one doctor for over 5,000 patients. We had two more doctors come in. I got to see my new doctor. He was there for three weeks and then left. I have no idea who my new doctor is, or have I ever seen him because the snow bird is right here, and getting an appointment when they are here is non-attainable.

I would like to say on my family side, my father put in 26 years. I have two brothers. All three of us retired from the military. My son just graduated AIT at Fort Huachuca, and he is going to Colorado, Fort Carson, 10th Special Forces Group. So, I am saying that.

I thank the committee for letting me address you. Thank you.

Mr. COFFMAN. Well, Mr. Anderson, thank you so much for your service, for the service of your family.

Mr. COFFMAN. Mr. Boales, you have 5 minutes. Thank you.

STATEMENT OF JERRY BOALES

Mr. BOALES. Chairman Coffman, Ranking Member Kirkpatrick, and members of the committee, my name is Jerry Boales, and I am the Director of Rock Soldiers for Wounded Warrior non-profit. Here in Arizona we service wounded warriors here in Arizona. Anyway, the testimony I am going to give today is the first time I have spoken openly about my personal experiences concerning this issue.

In 1989, I was stationed in the U.S. Army at Fort Riley, Kansas. During my time there I was attacked by three male soldiers, grabbed and pulled in a room. I was forcibly held down by two of the males while one forcibly raped me. I was then raped by the second male. The third male did not do anything except hold me while this was going on. I was told that if I said anything, I would be killed. I was in so much pain and shock that basically I was dragged to the stairs and was thrown down a flight of stairs, 20 stairs, and left alone. I passed out and woke up by the cadre. I could not move, so they sent me to the hospital on base. I became paralyzed emotionally, which I literally had to have a cattle prod taken and pressed on my feet to bring me out of the paralysis condition.

At this time I was so ashamed about what had happened that I did not report this incident, and I even told my father that I had slipped down some stairs and broke my arm. I had spent several

days in the hospital for this incident, knowing that I had been raped.

In 1990 I was discharged from the Army, so for the next 16 years I kept this to myself. I was married, had three children, and one night because of a nightmare, something snapped within me. The nightmares became so bad that I could not sleep and literally I was a walking zombie for not allowing myself to sleep. Finally after six years, I started seeing a nurse practitioner/counselor at the Show Low VA. I told her my story, and after a year she left and I had to see someone else. I would have to start all over again, which I just couldn't do.

So after about a year and a half, my wife encouraged me to seek help once again. I was really not wanting to talk to a male doctor about my experiences. I wasn't getting any better, so I did go back to the VA. I saw a physician, Dr. Davis. He could prescribe medications, so I continued to see Dr. Davis for almost two years. This was one-on-one counseling visits.

This time, I was recommended by Dr. Davis to submit for PTSD, depression, unemployability, which he documented, and I can also add that in his notes he related the military sexual trauma. I was denied PTSD relating from the military sexual trauma due to lack of evidence. However, I was service connected for depression 100 percent temporary, to be reevaluated after two years. I was originally denied Social Security disability twice, which took over another two years to get that approved through the use of a lawyer. This was because I could not work and was already diagnosed as chronic depression by the Veterans Administration.

I lost my family. I found myself living in a cabin as a recluse in Show Low almost two years. Before the cabin, I lived in a room in my ex-wife's home which I shut myself in and went out only after people were not around. I shopped at Walmart at 2 a.m. so I did not have to see people. I would go fishing at daybreak before anyone would be there.

In August of 2010, my son serving in the Army had been wounded in Afghanistan. He broke his neck, shattered his leg. I spent from August 2010 to November 2010 at Brooke Army Medical Center during my son's recovery. It was just me there with him. We had a lot of time to talk, but one of the last things he said to me during these conversations was, "Dad, promise me that you go seek help," which I did after returning to Show Low, and I contacted the Tucson VA, not the Phoenix VA, the Tucson VA.

I requested to make arrangements to get into the inpatient substance abuse program. February 2011 was the quickest time that I could go there, which I did. I stayed inpatient for three months and was finally able to get into the military sexual trauma inpatient group, which is a one-year program. So after being inpatient for three months at the VA Medical Center, I then left and would live in Casa Grande. I would commute once a week to Tucson for my group sessions. I did this for nine months. The group counseling was very intense, starting with a group of eight male veterans ranging from the Korean War, Vietnam, and current war. We ended with three finishing the program due to the intensity and having to relive the actual experiences.

Currently, today I see a therapist at the VA CBOC clinic in Casa Grande averaging every two weeks since October of 2013. I have submitted three times to the Veterans Administration for PTSD related to the military sexual trauma. I have been denied three times because of lack of evidence. I did not speak up when this rape occurred. I was too ashamed.

I want to acknowledge the Veterans Administration for finally recognizing that military sexual trauma is and has been an ongoing problem. However, being recognized is one thing; not being service connected and compensated with benefits is another. This feels that it is a slap in the face, like it never happened. If it is only being recognized for treatment, then the VA is only putting a Band-Aid on the problem. I am speaking for all male veterans who are going through these difficult experiences of military sexual trauma, as well as females too.

I realize that military sexual trauma is very difficult for anyone to talk about. But more and more, we are now seeing these experiences come out in the limelight. What is needed now? We need fair evaluation of personal stressors and physician diagnoses to service-connect and give our veterans benefits, what they deserve and, most important, need.

I would also like to comment on the veteran access to medical care, especially in the rural areas, based on my experiences. I first want to bring up that when I was in the military sexual trauma program for that nine months in outpatient, I had to drive 70 miles one way to attend sessions, Casa Grande to Tucson. This is 140 miles roundtrip. Even today, to continue the military sexual trauma individual or group counseling, I would still have to drive that distance. The program is good; the distance is not for any veteran in this situation.

I might add, even in Show Low, if it was to see a specialist for my knee or shoulder, I would have to travel to Phoenix, which was almost 400 miles roundtrip. Living in a rural area, I would like to see more specialists and physicians that can do immediate care, not having veterans constantly trying to get appointments. I recently had to deal with the same problem——

Mr. COFFMAN. Mr. Boales, you are over time. Please sum up. Thank you.

Mr. BOALES. I would like to see a fully staffed VA clinic and maintain that VA staff to assure myself and all veterans quality health care in a reasonable timeframe. I also recommend a vet center in this area that veterans can go to and seek counseling for PTSD, TBI, sexual trauma and concerns related to these issues. It is important to me, and I know it is important to every veteran living in the Casa Grande Valley.

[THE PREPARED STATEMENT OF JERRY BOALES APPEARS IN THE APPENDIX]

Mr. COFFMAN. Thank you, Mr. Boales. Thank you for your service.

Mr. Davison, you are now recognized for 5 minutes.

STATEMENT OF JOHN DAVISON

Mr. DAVISON. Thank you, Honorable Chairman Coffman, Ranking Member Kirkpatrick, Ms. Sinema. It is a pleasure to be with you today. I am here representing my son, Lance Clinton Davison, who is deceased, who we lost recently, just before sunrise on February 9th, Sunday, February 9th. He succumbed to his wounds that he received in two wars, Afghanistan and Iraq in the Middle East, and he took his life.

I have submitted written testimony to the subcommittee with addendums that appropriately characterize and honor my son and his service to his country. But in the few minutes that I have, I wanted to read a letter that Lance had written in his defense to the Superior Court of Maricopa County about two years ago, and I think it pretty well sums up his circumstance and his frustration with not only the military and the VA but also with himself. So I will read that now.

"My name is Lance Davison. I am writing and petitioning to have my judgment set aside or vacated; also to reinstate my right to bear arms for employment purposes. I understand the initial severity and the potential of my actions on the night in question. It changed my life and deeply affected others. However, I contend this incident is a result of psychological stress from years of service to my country and community.

"I am a United States Marine in a Special Operations Unit known as MARSOC, Marine Special Operations Command, with nine years of service and multiple deployments to Afghanistan and Iraq. I was decorated multiple times for my actions. I was formerly a police officer, with citations for my actions in line of duty.

"For nearly seven years, my country asked me to perform acts of violence on its behalf. I have lived and experienced life well outside the normal human condition. I firmly believe there exists a mental threshold that each man owns. I may have spent mine.

"I developed a condition commonly referred to as PTSD. Years in combat zones have left me wounded both physically and psychologically. I have witnessed war on a very personal level, and have even become comfortable with it. When I returned home I was diagnosed with PTSD and immediately placed on drugs, in my best interest. My wife at the time was concerned that I had changed, and maybe the drugs would help.

"Post-traumatic stress was amplified after a shootout as a police officer in which I nearly lost my life again. I don't fault the professionals at the Veterans Administration. I was kept on a regimen of drugs that have psychotropic properties, drugs I have found I was very sensitive to. The administering of drugs started after my last deployment after I sustained injuries in combat. These drugs were DoD approved.

"However, upon my discharge from the Marines, I was given another set of drugs through the Veterans Administration. Each regional hospital has its own formularies or set of drugs doctors administer, so the experimentation began to find a cocktail that doesn't upset my mental chemistry.

"So when I moved from the Northern Arizona Health Care System to the Phoenix Regional Health Care System, I was administered a new cocktail of sleep aides, antidepressants and drugs that

classify as psychotropic. By the time I was finally pulled off the drugs and it was deemed that I was too chemically sensitive, I had 32 different cocktails, 32 different combinations of drugs.

"The circumstances I found myself in was that I never had a consistent care provider. People would leave and move on to other jobs, so there was no safety net. Episodes would occur, and it was always attributed to PTSD. No one immediately examined the pharmaceuticals.

"On some level, PTSD was a major factor, but there was these drugs that were constantly changing. The dosages would increase, other drugs would be added, until I could barely function.

"I was taken off the drugs after there was concern that TBI, traumatic brain injury, may be causing some of the symptoms. After six years of being on medication, I stopped. That was February 8, 2011. No one fully knows the effect of these pills on an individual with blast injuries.

"There is also a condition called serotonin syndrome. Like any other drug, a detox period is needed. I had severe withdrawal. My mind was frayed. In no other state would I ever burn my porch and driven my truck into a pool. I was hallucinating and was simply reliving my time in Iraq in 2003.

"I experienced a dissociative episode that involved my brain's inability to produce serotonin and other regulating chemicals. I urge you to read the medical records provided. I was drinking, and for that immediately the onus shifts. I was attempting to alleviate my symptoms and the kaleidoscopic mental circus. I have taken responsibility for my actions and poor decision to self-medicate with alcohol. I have taken responsibility for handling my situation and my condition poorly. I went above the court's recommendation and spent 50 days in an inpatient PTSD and alcohol treatment program.

"However, just like in combat, there are no right answers. You just search for the best answer. This incident wasn't born of malice or criminal intent, just an unfortunate sequence of events and an old, broken Marine trying to make sense of it all.

"I ask the court to vacate or set aside the judgment and reinstate my right to bear arms so I can continue with my profession, move forward as a successful, functioning, and contributing individual.

"Thank you for your time and consideration."

So from that point on, Lance took charge of his life. He created his own disabled veteran-owned business and was doing well, and we were all very blindsided by the tragedy that struck him because we thought he had been making such positive improvement. But it is obvious, as you can see, his past just was very problematic.

So I hope that the subcommittee will take these issues very serious, and the best way to honor Lance and military personnel like him, veterans that have PTSD and TBI, is to correct the problem so that no other young men or women have to make this choice, because I do believe that Lance's character is firm and that he just didn't want to become what it was making him, so he had to make a choice.

Thank you.

[THE PREPARED STATEMENT OF JOHN DAVISON APPEARS IN THE APPENDIX]

Mr. COFFMAN. Mr. Davison, thank you so much for your testimony and for the service of your son, and I am very sorry for your loss.

Mr. Hazell, you have 5 minutes.

STATEMENT OF BRADLEY HAZELL

Mr. HAZELL. Thank you, Chairman Coffman, Ranking Member Kirkpatrick, Representative Sinema. Thank you very much for having me here today.

I served in the Marine Corps from 1999 to 2005, where I served two tours in Iraq. During my second tour in Iraq as an infantry squad leader, my squad was hit by two IEDs, the second of which killed one of my Marines and wounded three, myself included.

Upon returning to the States, I resumed my life and returned to my civilian job. I had already started to struggle with PTSD symptoms. Within a year of being home I had gotten to the point where I was self-medicating with alcohol daily. Eventually I came to the conclusion that I could no longer deal with these issues myself, and one night I called the Veterans Crisis Line. The following day I went to the closest VA clinic, which was located in Alexandria, Virginia. I was extremely fortunate that, due to my desperation, the VA counselor saw me that day even though I had not yet been enrolled in the VA system.

I began weekly sessions with a counselor and had monthly appointments with a psychiatrist. Eventually I agreed to be treated at an inpatient facility located in Martinsburg, West Virginia. First I was treated for alcohol abuse, and then I was treated for PTSD. Unfortunately, due to the intense emotions that accompanied the PTSD program, I withdrew myself and returned to work. Within a year I decided to return home to Arizona, when I moved to Phoenix. I was given a three-month supply of medications with instructions to enroll in the VA Health care System upon my return.

Upon arriving in Arizona, I immediately began looking for work. I had two jobs, both of which lasted two months. I ran out of my medication and attempted to manage my PTSD on my own. After being without medications for over a month, I became emotionally distraught and finally enrolled in the Phoenix VA Health care System. When I attempted to make an appointment to be seen by a psychiatrist so I could resume my medication, I was informed that I had to wait at least a month, if not longer. At this point, I had already been without medication for two months.

I pleaded with the hospital to see if they could at least refill my prescriptions that I had when I had been living in the DC area. The Phoenix VA Hospital's solution was to treat me inpatient at their mental health ward. This only made matters worse. Within three days I demanded to be released and signed myself out of the hospital. The doctor refused to put me on the same medication, stating that some of the medications were not in the Phoenix VA Health care System's formulary.

After leaving the mental health ward in Phoenix, I moved in with my mother in Casa Grande. Living in Casa Grande, I was now in the jurisdiction of the Southern Arizona VA Health care System. My experience has been much better since. I was seen within two weeks by a psychiatrist at the Tucson VA Hospital and

started therapy with a counselor at the Casa Grande Community Based Outpatient Clinic. The Southern Arizona VA Health care System fell under yet another formulary, and they were able to put me on the same medications that I was on while living in DC. Over several years my medication was decreased and I vastly improved.

Unfortunately, PTSD hits in waves. I missed an anniversary date from an incident in Iraq during which several Marines from my unit were killed. This sent me into a severe depressive episode. I canceled my appointments with my counselor and my psychiatrist. After several months of this depressive episode I eventually tried to take my own life by overdosing on a three-month supply of sleeping pills. I awoke several days later in an intensive care unit and was then transferred to the Tucson VA mental health ward, where I stayed for several weeks.

Prior to discharge, a safety plan was implemented and I was placed on a high-risk list with the VA Health care System. That being said, when I was discharged and I first tried to make a counseling appointment when I left the hospital, I was told it would be several weeks until I could be seen. When I informed the receptionist about my recent hospitalization, she saw the flag in the system and I was seen several days later.

I remained on the high-risk list for several months until my mental health care providers deemed that I was safe to be taken off. Since that time I began working as a veterans' advocate, helping veterans navigate the Veterans Benefits Administration. To this day, I am still treated by the Southern Arizona VA Health care System.

Thank you very much for your time.

[THE PREPARED STATEMENT OF BRADLEY HAZELL APPEARS IN THE APPENDIX]

Mr. COFFMAN. Mr. Hazell, thank you so much for your service to the United States Marine Corps, to this country.

We will begin our round of questions.

Captain Gatlin, you were examined by three Department of Defense physicians over the course of three years and received a 70 percent disability rating for mild TBI when you were medically retired. How do you explain the 10 percent rating by the Veterans Administration?

Captain GATLIN. Honestly, I can't. I am still up in the air with it. I just can't believe it.

The way the VA works I think with the C&P exam is you have I think it is an hour video that you watch, and you have to post back questions on the Internet. We could all take it right now and we could all see patients because you don't have to have a license to do it. I think that is a huge issue, first and foremost.

Two, I think that the VA—and I can't really speak to the larger picture, just the Montana, Helena VA, the Fort Harrison VA. Their system intentionally lowered ratings. They are using faulty tests, and they know it. Hopefully, that will come out a little bit later.

And three, I think it is this. We all watch sports I guess to some extent, and if you ever keep up with the NFL, it changes. You have head concussion rules coming out there now. The kickoff has been

moved. They are talking about moving the extra point, which I am totally against, by the way.

[Laughter.]

Captain GATLIN. But when you look at the VA, with the quality of soldiers coming back, some of their socioeconomic-geopolitical problems, something has to change. I mean, I don't know when these rules were put in place, but they have to change. They are not progressive, and they are so dug in. When you come in to get them, they tell you that you are attacking. I mean, what is a young soldier, let's say 18 to 22 years old, TBI as a secondary injury behind a more primary life-threatening injury, married, a couple of kids, living in the middle of nowhere Montana, what are they going to do? I mean, maybe they don't have the initiative or the attitude that I have sometimes—I get criticized for it a lot—to be able to come forward and stand up for themselves and stand up for others.

So what they are doing, Congressman, is they are systematically lowering ratings and keeping their fingers crossed that nobody says anything about it.

Mr. COFFMAN. Mr. Duplisea, VA has proposed diminished funding for TBI treatment. Please describe the Wounded Warrior Project's reaction to this proposal, if there is a position.

Mr. DUPLISEA. We consider the proposed cut in funding troubling. One big reason for that like I said in the testimony, is that Congress—you—have already enacted a law, that requires VA to improve long-term TBI rehabilitative care. We want VA to implement that law. Like I said in the testimony, when someone is suffering from a TBI—and I had a severe TBI, and clinicians use the word "plateau,"that suggest there's no room for further improvement. Personally I just don't believe in that word in someone with a TBI. The brain is the most complex organ in the body. I think it is hard for a doctor or a clinician to say that someone has plateaued when that warrior inside knows they have not plateaued.

And what is to say, too, that after that warrior has gone through step-by-step-by-step help, and we stop it, that warrior will not regress?

Mr. COFFMAN. Ms. Del Negro, can you briefly describe the I guess it is RBANS—and I understand that is Repeatable Battery for the Association of Neuropsychological Status—assessment tool and how it was misused during the C&P examination? Do you know if it has been used elsewhere?

Ms. DEL NEGRO. I am not a medical professional, but I do dabble a little in the medical arena. My familiarity with RBANS was nonexistent prior to this experience, and it was only upon us bringing it to the attention of the Board of Psychologists that we learned, in fact, that RBANS is a screening test that is primarily used for dementia in the elderly. It has been studied in various different very small studies for its application to evaluate cognitive dysfunction in other disease states such as Alzheimer's, and in moderate and severe brain injury as well, but the results are not well established enough to be making firm generalizations about its use in practice.

The psychologist who used the test, my impression dealing with the system is that the test was not endorsed by the system, the CPEP training, as my husband was mentioning before. Rather,

however, despite the fact that he used this test and he used it inappropriately—for instance, the results of the testing actually confirmed what my husband's complaints were, but he disregarded those test results and attributed any complaints of cognitive disorder to PTSD.

So it was just profoundly unprofessional all around, but the RBANS is being used or has been used previously at, I believe it was, the Texas VA, and that was at the admission of the psychologist in question, who issued in his statement that this was a test that had been used in other VAs, and his immediate supervisors condoned the test. They said he followed protocol.

Mr. COFFMAN. Thank you.

Mrs. Kirkpatrick.

Mrs. KIRKPATRICK. Thank you all for your testimony and for being here today. I have a question for each one of you. I want to hear from each one of you.

We know there are multiple problems in the system, but in an effort to move forward in a positive way after today's hearing, I would just like to ask each one of you what would be the number-one thing the VA could have done to make a difference in your experience?

And, Mr. Hazell, we will start with you.

Mr. HAZELL. Whenever veterans move from one area to another, the VA doesn't keep track of them. When I moved from DC to Phoenix, it would have been nice if there would have been something set in place to automatically transfer my files so I could have resumed receiving treatment immediately. Additionally, all the hospitals operate on their own independent system. As a result, none of them use the same criteria for how they prescribe medication. So once again, veterans have to start from scratch. Thank you.

Mrs. Kirkpatrick. Mr. Davison.

Mr. DAVISON. I just wanted to say that I think that one of the primary things that the VA needs to do is we need to have a complete and thorough investigation and review and evaluation and an updated strategy to deal with PTS and TBI. It is the signature medical condition for OEF and OIF veterans. Only through that kind of evaluation and scrutiny can we—we are learning new things every day in science and technology, and I think that just hasn't been applied yet and we are really doing old-school-type things to deal with these veterans' problems, and we need to come up to speed to the 21st century.

Mrs. Kirkpatrick. Mr. Boales.

Mr. BOALES. For me, it would be keeping our rural area CBOCs 100 percent staffed and maintaining that 100 percent staffing. And even at 100 percent staffing, in certain departments such as Casa Grande CBOC, CBOC's physical therapy department, it is not staffed near enough with only one person to accommodate the needs of all of our veterans recovering from major joint surgeries in Pinal County, let alone all the other physical therapy needs our veterans need.

Mrs. Kirkpatrick. Mr. Anderson.

Mr. ANDERSON. A big part where that would be is don't start off with a big mixture of drugs, start off at a smaller dose. If they need

a little bit more, then go from there. Don't start at the top and go from there, because then they want more and more.

Also, I would like to see them utilize those veterans that are at a certain level of recovery from TBIs or PTSD, similar to the AA where you have another veteran that you can call that understands your problems, that understands what you are going through. You are like those people. Have a buddy system where he can call and you can talk about it, instead of getting strapped to a chair and shoved in a room and given drugs.

One more deal on that is we have a lot of service members that got dishonorably discharged that aren't eligible for veteran care, and a lot of that is PTSD. What about those soldiers? Mr. Chairman, you have been in the service. You know that you have seen those guys come back after a conflict and get into trouble, whether it be DUI, alcohol abuse, spousal abuse, domestic violence, where they are dishonorably discharged from the service. That is like having a felony on your record. Those people also need to be looked at and taken care of.

Mrs. KIRKPATRICK. Thank you, thank you.

I just have a few more minutes, so I will just quickly go through the last three.

Captain GATLIN.

Captain GATLIN. Leadership, honesty, transparency, and accountability. When you have a problem, maybe it is not a problem yet. At what point does Tier Level 1 leadership step down and kind of see what is going on? It is kind of like a general walking amongst the privates. "Hey, what's going on?" The private kind of feels better. The general has firsthand feedback to what is going on.

The VA just plays the VBA against the VHA. I don't know if you have ever read John Grisham's "The Rainmaker" with the great benefits, but that is the VA. That is how they operate. And you, if you don't have the initiative or the resources, you get pushed out and you get frustrated when all these things these gentlemen were just talking about start to occur.

So leadership, honesty, transparency, accountability by senior echelon leadership.

Mrs. KIRKPATRICK. Thank you.

Ms. DEL NEGRO.

Ms. DEL NEGRO. I think that was very well stated in terms of picking which option I wanted to go with. I think I would just say that the system doesn't care or is not aware of the stresses that are being placed upon the family. When you have a veteran who has a deep TBI, and then the emotional underlying issues, then the stresses from that situation are compounded, and that can affect the family members and the caregivers, and the burden the system is placing on those families is ridiculous.

So I wish that they had been able to acknowledge that and address it accordingly.

Mrs. KIRKPATRICK. Thank you.

Mr. Duplisea.

Mr. DUPLISEA. My experience at the Tucson VA has been exemplary. But for warriors, veterans outside of Tucson, I ask that Congress enforce the TBI law for lifetime care and give effective and

timely care for mental health issues such as PTSD, depression, anxiety in warriors that exhibit suicidal ideations.

Mrs. KIRKPATRICK. Thank you all very much.

Thank you for extending my time, Mr. Chairman. I yield back.

Mr. COFFMAN. Congresswoman Sinema, you are now recognized.

Ms. SINEMA. Thank you, Chairman Coffman and Ranking Member Kirkpatrick, for allowing me to participate today and for holding this hearing in Arizona.

Chairman Coffman, thank you for coming to our state. We have a very proud military tradition here in Arizona, and this issue is important to all of us.

Congresswoman Kirkpatrick, you are a great champion for Arizona veterans.

So I am glad that you brought the committee here to Arizona to hear directly from veterans.

And thank you to our panelists. Thank you for your service to our country, your sacrifice, your family's sacrifice, and for your advocacy and courage to stand up for all of our nation's veterans.

I believe it is critical that our veterans have access to appropriate care. Traumatic brain injury's mental health wounds are the signature wounds of the wars in Iraq and Afghanistan. But previous generations of our country's warriors also have these wounds. As was noted by the panel, we lose 22 veterans a day to suicide. It is unacceptable.

I am also extremely disturbed by recent allegations about the Phoenix VA Medical Center in my district that delays and may cause the deaths of upwards of 40 Arizona veterans. We must get to the bottom of this and hold accountable those who are responsible.

I think that no veteran should ever feel like he or she has no place to turn, and no family should lose their loved one after he or she returns home.

My first question is for Mr. Duplisea, Mr. Anderson, Mr. Davison. You each testified to either your own experience or the experience of your son who developed a relationship with a VA professional, only for that employee to leave and for the veteran to have little or no warning, forcing them into either a start-over period or, in some cases, without any care at all for an acceptable period of time.

We know that many PTSD and TBI patients don't have a reliable safety net. There was a veteran in my district, Daniel Summers, who committed suicide last summer. He had post-traumatic stress disorder and a traumatic brain injury. He was first placed into group therapy, which was not an effective place for someone who served in classified service. Later, his VA professional left with no warning, and with nowhere to turn he committed suicide.

My question for each of you who either yourself or your family member have experienced something similar, do you have a suggestion of what the VA could do differently to ensure that veterans like yourself and your son are not left in a situation without the mental health care professional who they formed a bond with and who they trust?

Mr. Davison, Mr. Boales, Mr. Anderson, Mr. Duplisea, feel free, any of you, to answer.

Mr. DAVISON. I think a critical component is to engage local communities. This would also be a cost-effective way to mitigate these problems for our veterans. If they worked with local veteran service organizations and communities and we all got involved, and the VA would consider out-sourcing and at least partially fund these type of efforts, I think it would bring it home for veterans.

I know in my community there are a lot of veterans with PTSD, and what happened to Lance touched them deeply, and it was very tragic, and it shook them up, and they are starting to say we have to do something for ourselves.

So if the VA would look at partnering with local VSOs and community groups and working together, because it is not just the VA's problem, it is not just the United States military's problem, it is our problem as a nation, and it is our duty, it is your moral obligation as leaders and as government officials to fulfill the promises that we have made to veterans. But it is also our duty as citizens and former veterans to come together to help them because, like you mentioned, 22 a day, it is a national tragedy and it is an epidemic that has extreme ramifications for the military and for our nation.

You said it; it is unacceptable. We cannot allow this to continue.

Ms. SINEMA. Thank you.

Mr. Boales.

Mr. BOALES. For me, Congressman Sinema, for me and my personal experience, I have seen over five health care providers, and each one of them, the reason why I saw them was because one left, and so I had to see another. It was hard for me to talk to a male, number one. So for me, the providers looking at the charts and reading up on the charts and knowing the patients, talking to the previous provider, knowing that this gentleman is not comfortable in certain situations.

Two, maintaining staffing.

And three, again, it is so imperative for me—all my care for the last 24 years, I have been in the Tucson VA system, which has been great, and I have been in the Phoenix VA Health care System, and the rural Health care system is so understaffed for the care that is needed.

Telemed. For me, I cannot do Telemed, and that is provided. It is not one-to-one conducive to speak about. So that is not an option for me. So I am looking at 140 miles if I want to continue care, and I do the best I can.

So staffing, reviewing the charts, knowing the patient, this gentleman is not going to be comfortable with a male. And yet, that is who I get. So I stopped.

So that would be my suggestions.

Mr. ANDERSON. And I am pretty much on those same sentiments. Like I said, my first health care provider, she basically told me when I first started was from Monday at 8:00 to Friday at 5:00, that is when she was on the clock, because I asked her to review some tests, psychological tests that I received. And talking to that psychologist in Phoenix, it was supposed to be an hour-and-a-half test. It turned out to be six hours, because he kept giving me these tests and he was telling me stuff about my life that made so much sense. And he said, well, I am contracted through the VA, I can't

really treat you, because that was kind of crossing the line there. Get with your health care provider.

So that was sent to her on Friday. I had an appointment with her on Monday. I was all excited to see her, and she said, well, I didn't review that because I don't work on the weekends. It was that type of attitude that just kind of shot me down.

And then like he was saying, the teledoc, he doesn't care. I mean, okay, you know what? You don't want to take my meds? Then, you know what? We are done here, so we stopped.

The big problem I see is that when we do have—especially our young soldiers. I speak a lot for our young soldiers. When they come in there and they have a problem, most of them have young families. And if there is alcohol, drugs, got out of the military, having trouble at home—because that is what PTS does, you know? All those little problems keep piling up and piling up, and you are digging that hole, and you are digging that hole, and it takes the VA so long to recognize it and to try to get them some help, whether it be psychological or financial.

Meanwhile, that guy is going to China. He is digging this hole, and it is going deep, and there are a lot of problems out there with our younger veterans, and we are not doing nothing about it.

Ms. SINEMA. Thank you.

Mr. DUPLISEA. Well, the VA is a very complex system, and problems with the health care are also very complex, and there is no silver bullet or cure-all for these issues. But for me it comes down to staffing, and it also comes down to the accessibility of mental health care here in VA. You have to have invested proven staff that are invested in helping veterans, helping warriors with mental health issues.

Here at the Tucson VA I have been very fortunate to have that since I came here in 2008, but it is not the same everywhere. I came here and I had one mental health clinician, then I went to another one, and they were very accommodating because I was working during the day and I couldn't make the appointments. I asked if they had a plan in place where they could help me to come after hours, and they did have a clinician who accommodated that, and I greatly benefitted from that counseling that I received. Actually, it lowered my severe PTSD to mild PTSD, from 50 percent down to 10 percent.

So I am proof that the system does work, again here in Tucson, Arizona, but it is not the same everywhere. Tucson is the model and it is an exception, but all VAs should be just like Tucson.

Ms. SINEMA. Thank you.

Thank you, Mr. Chair.

Mr. COFFMAN. Thank you.

Panel, I would like to thank you so much for your testimony today, for your service to this country, and for the members of your family that have served this country.

Mrs. KIRKPATRICK. Thank you for your selfless courage in coming today and testifying. You have made history. You have helped the committee, given us some direction in how to move forward. So, thank you from the bottom of my heart very much.

Mr. COFFMAN. I now would like to invite the second panel to come up to the witness table.

Again, thank you very much.

On our second panel we will hear from Dr. Lisa Kearney, Senior Consultant for National Mental Health Technical Assistance of the Office of Mental Health Operations, Veterans Health Administration.

She is accompanied by Dr. Joe Scholten, National Director of Special Projects for Physical Medicine and Rehabilitation Services, Veterans Health Administration; Mr. Jonathan Gardner, Director of Southern Arizona VA Health Care System; Mr. Joshua Redlin, Licensed Clinical Social Worker and Team Leader for the Tucson Vet Center; and Mr. Rod Sepulveda, Rural Health Program Manager of the Northern Arizona VA Health Care System.

Dr. Kearney, your complete written statement will be made part of the hearing record, and you are now recognized for 5 minutes.

STATEMENT OF LISA KEARNEY, PH.D., SENIOR CONSULTANT, NATIONAL MENTAL HEALTH TECHNICAL ASSISTANCE, OFFICE OF MENTAL HEALTH OPERATIONS, VETERANS HEALTH ADMINISTRATION; ACCOMPANIED BY JOE SCHOLTEN, M.D., NATIONAL DIRECTOR OF SPECIAL PROJECTS, PHYSICAL MEDICINE AND REHABILITATION SERVICES, VETERANS HEALTH ADMINISTRATION; JONATHAN H. GARDNER, MPA, FACHE, DIRECTOR, SOUTHERN ARIZONA VA HEALTH CARE SYSTEM, VETERANS HEALTH ADMINISTRATION; JOSHUA D. REDLIN, LCSW, TEAM LEADER, TUCSON VET CENTER, U.S. DEPARTMENT OF VETERANS AFFAIRS; ROD SEPULVEDA, RURAL HEALTH PROGRAM MANAGER, NORTHERN ARIZONA VA HEALTH CARE SYSTEM

STATEMENT OF LISA KEARNEY

Dr. KEARNEY. Thank you, sir. First, I would like to express our appreciation to the first panel. Thank you for sharing your stories with us. And especially I am very appreciative of the feedback that they all gave to you, and we have taken notes on that and will be following up on that. We very much appreciate that. And to Mr. Davison in particular, our hearts go out to you.

Chairman Coffman, Ranking Member Kirkpatrick, and members of the committee, thank you for the opportunity to appear before you today to discuss access to treatment for veterans with traumatic brain injury or post-traumatic stress disorder once they return home.

I am joined today by Dr. Joel Scholten, Special Projects Director for the Physical Medicine and Rehabilitation Program; Mr. Jonathan H. Gardner, Medical Center Director at the Southern Arizona VA Health Care System; Mr. Joshua Redlin, Team Leader at the Tucson Vet Center; and Mr. Rod Sepulveda, Rural Health Program Coordinator for the Northern Arizona VA Health Care System.

VHA provides state-of-the-art, comprehensive health care and support services for veterans with both combat and civilian-related TBI through the Polytrauma System of Care. Through this program, the Department continues to advance the evaluation, treatment, and understanding of TBI in a variety of ways: by, one, developing and implementing best clinical practices for TBI; two, collaborating with strategic partners including veterans' families and

caregivers, veterans' service organizations, the Department of Defense and other government agencies, community rehabilitation providers, and academic affiliates; by providing education and training and TBI-related care and rehabilitation; and finally, by conducting research and translating findings into improved clinical care.

This system is designed to assist veterans with TBI and polytrauma in a seamless transition between the Department of Defense and VHA. It also assists a veteran with their transition back to their home community through the provision of evidence-based rehabilitation services and care coordination.

VA is one of the largest integrated health care systems in the United States that provides specialized mental health treatment for PTSD. In Fiscal Year 2013, over 530,000 veterans received treatment for PTSD in VA medical centers and clinics. VA provides care for PTSD in a variety of settings, delivered by more than 5,200 VA mental health providers who have received training in the most effective known treatments for PTSD.

VA also operates a National Center for PTSD that provides research, consultation, and education to clinicians, veterans, family members, and researchers. The National PTSD Mentoring Program, which works with every specialty PTSD program across the country, is designed to promote evidence-based practice within the VA.

Southern Arizona VA serves as a polytrauma network site in VISN 18 and coordinates key components of post-acute rehabilitation care for individuals with polytrauma and TBI across the VISN. Since 2010, the facility has seen a 70 percent increase in TBI and polytrauma visits completed via TeleHealth with veterans residing in rural and highly rural areas, making up as much as 37 percent of the overall rehabilitation workload in Fiscal Year 2013.

Southern Arizona has also worked closely with community partners to develop multidimensional programs such as the Adaptive Sports Program, the VISN 18 Program for Managing Veterans with Complex Pain, a Vision Therapy Clinic, and the Headache Management Clinic.

Southern Arizona's VA Polytrauma Network site also engages with the Arizona Governor's Council on Spinal and Head Injuries, the Arizona Coalition for Military Families, the University of Arizona, Pima Community College, the Arizona Department of Economic Security, and others to better serve the vocational rehabilitation goals of injured veterans.

On August 14th, 2013, Southern Arizona VA hosted a mental health summit with over 90 community participants. Southern Arizona VA will be hosting another mental health summit in August with a focus on mental health access.

Southern Arizona VA provides comprehensive mental health services, which also includes primary care mental health integration. This program supports primary care PACT by providing a mental health psychiatrist and a team of social workers who are co-located in the primary care clinics. In Fiscal Year 2013, this program served over 5,000 unique patients with nearly 16,000 clinical encounters.

In addition to providing a wide range of social and psychological services to eligible veteran service members and families, the Tucson Vet Center also provides community outreach, education, and coordination of services with community agencies.

In closing, first let me apologize, Congresswoman Sinema. I did not recognize you earlier. We are glad that you are here today.

VHA provides comprehensive health care and support services for veterans with both combat and civilian-related TBI and PTSD. The VHA is continually working to further enhance these services through quality improvement initiatives, and we are grateful for the support of Congress and our community partners to assist us in these endeavors.

Mr. Chairman, this concludes my testimony. Thank you for the opportunity to appear before you today. At this time, my colleagues and I are pleased to respond to any questions you may have.

[The prepared statement of Lisa Kearney appears in the Appendix]

Mr. COFFMAN. Thank you for your testimony.

Dr. Kearney, the Administration's budget request for Fiscal Year 2015 is for $229 million for TBI medical programs, down 1.3 percent from Fiscal Year 2014, the current year. In light of this reduction, how will VA ensure that veterans with TBI receive quality care and are not short-changed as they live with their disabilities?

Dr. KEARNEY. Thank you. Mr. Chairman, we are very committed to continuing good care for each of these veterans. I would like to refer this question over to Dr. Scholten, our expert in traumatic brain injury.

Dr. SCHOLTEN. Mr. Chairman, thank you. And again, let me thank the first panel for their testimony today. We do take their experiences back to VA central office, as well as to the medical centers where we practice, in order to improve our practices.

In regards to the budget for traumatic brain injury care in VA, we have seen, fortunately, a decrease in the number of severely injured service members requiring inpatient rehabilitation from combat-related injuries. That does significantly affect the overall cost or the overall expenditure of TBI care.

In Fiscal Year 2013, we were down to 54 foreign theater injured combat wounded that were treated in our polytrauma rehab centers. That was down from 132 in Fiscal Year 2012.

When we look at all of the cases, all individuals with a TBI diagnosis in the system, there has been a significant downward trend in those individuals where the cumulative cost, the annual cumulative costs are greater than $50,00 per fiscal year. So in the OEF/OIF/OND population, that has gone down from 4.9 percent in Fiscal Year 2010 to 3.6 percent in Fiscal Year 2013, which results in a significant decrease in total expenditure.

Similarly, the percentage of non-OEF/OIF TBI cases with care costs greater than $5,000 per year have also decreased, down from 12.2 percent in Fiscal Year 2010 to 10.5 percent in Fiscal Year 2013. We feel that, in relation to the care that is being provided, we know that DoD has stepped up their efforts to identify individuals with traumatic brain injury. We know from the Congressional Budget Office that costs for TBI care decrease over time. So the first year is the most expensive, and we feel that that is contrib-

uting to the overall decrease in the overall cost for TBI care despite the fact that we are seeing more individuals with TBI.

Mr. COFFMAN. Dr. Kearney, can you explain how a veteran receiving 70 percent disability at the time of his military discharge due to a mild TBI can be reduced to only 10 percent by the VA? How can this in any way be considered a seamless transition?

Dr. KEARNEY. Thank you for the question, sir. I cannot comment specifically about this particular case. I will tell you that each of our examiners are trained in a particular way using the training that they have put before them in order to reevaluate, but I can't speak to this particular case. I don't know the details of the case to be able to respond to that question.

Mr. COFFMAN. Are those examiners required to be licensed in their respective states?

Dr. KEARNEY. We have a requirement for our C&P examiners to be licensed. There is in the VA, for psychologists in particular, you can be hired as a provisional psychologist in which they are reviewed for two years and they have supervision during that time, and they must obtain licensure during that time before they can stay with the VA. If they do not obtain licensure in that time, they are under clinical supervision, much like our trainees.

Mr. COFFMAN. I think the testimony today clearly states that there is a problem, and it needs to be resolved.

Could you talk about how VA coordinates with Indian Health Services to ensure that Native American veterans receive adequate reimbursement, as well as quality medical care?

Dr. KEARNEY. I don't have any particular comment on Indian Health Services today, but I do want to ask Mr. Gardner if he could speak particularly to that in the Tucson area.

Mr. COFFMAN. Coordination? Sure.

Mr. GARDNER. From the coordination standpoint, again, we deal with the Tohono O'odham Nation, which is just south of us here, and we do have a coordinator that goes out on a regular basis, interacts with the staff of the Sells (Anqone) IH unit, as well as looking for veterans. We have several outreach efforts where, in fact, we look for veterans that are interested in becoming a patient of ours and go ahead and get them enrolled.

We attempt to make sure with our Native American veterans that we are culturally sensitive. We have a program in place here in Tucson where we have trained over 400 staff, and we try to put them through a process where they learn a little bit about the Native American way, and they are taught by Native American healers, and it is important to us that happen.

We also work closely with IHS, Mr. George Bearpaw, who is the regional director, and coordinate with him to make sure that services that eligible veterans can be connected with, we connect with them to make sure that transfer is made.

Mr. COFFMAN. Thank you.

Representative Kirkpatrick.

Mrs. KIRKPATRICK. Dr. Scholten, nice to see you again. You and I visited your polytrauma unit and you gave me a tour. We talked about how we could prevent losing some of these veterans in the transition process and that it would be really good if the Depart-

ment of Defense would notify you before the member becomes a veteran.

Are you seeing an improvement in that notification? Do you get medical records before the military member transfers out of the service?

Dr. SCHOLTEN. Thank you, Congresswoman. I would like to answer that question in two parts, both from my position in VA central office, as well as a treating physician at the Washington, DC, VA.

I think most importantly from a treating physician standpoint, I do get medical records as patients transition from DoD to VA. Some of those records are available through our Vista Web system within the medical records system, and I have been pleasantly surprised to be able to see more records even from care delivered in theater for veterans that have entered the system and maybe have gotten treatment a year or so before.

When it comes to the most seriously injured, those individuals that are typically treated inpatient in a military treatment facility and then transitioned to one of our polytrauma rehab centers, that process is very seamless. We work very hard to introduce both the injured service member and their family to the receiving treatment team by use of a video teleconference. That allows the teams and the caregivers and the injured service member to talk about needs, to talk about transition issues and logistics of the transfer, as well as get to know what is going to happen when they arrive at the VA.

In addition to that, the VA liaison that is embedded at the military treatment facility helps to make sure that all the records are available. They do a nurse-to-nurse handoff as well. And then some records are available in the computerized record system. But as a safeguard, veterans carry a hand-delivered CD copy of all of their records from the military treatment facility as a safeguard.

For those individuals that are being treated at a military treatment facility and living in a warrior transition unit or residing in a WTU, the VA military liaison that is embedded there will contact the OEF/OIF/OND VA program manager at the receiving VA and ensure that information is transferred and that a case manager is assigned. The goal is for the case manager to contact that individual before the transfer actually happens, as well as begin to set up appointments and coordinate care once they arrive at the receiving VA.

Mrs. KIRKPATRICK. And what about the drug formulary? Do you find that it is compatible, that you can continue the same course of treatment that they were receiving in the military when they get into the VA system?

Dr. SCHOLTEN. That varies by patient or by individual veteran. There are some medications that are on the DoD formulary and not, for instance, on the Washington, DC, VA formulary. However, I think it is very important to note that the ordering of medications is done by the practitioner, the physician that is working with the patient, and there is a discussion about what has worked in the past, what the current medications are. And if a medication is not on the formulary that it is determined to be the correct medication,

there is a non-formulary process that you can go through and get that medication. So it does work.

Mrs. KIRKPATRICK. Dr. Kearney, I know there has been a big increase in telemedicine, and a lot of the veterans I have talked to like that. But we heard in the first panel a veteran who doesn't feel comfortable with that. So what accommodations can you make for folks who really aren't comfortable talking with their doctor over the computer system?

Dr. KEARNEY. Yes, I think that is a really important concern. We want to make sure that each of our treatment plans that we work collaboratively with our veteran is something that they are comfortable with. So that is part, when they are having those initial discussions about plan of care, are they comfortable with tele-mental health services, would they prefer group or individual treatment, asking them these different things.

Another option that we are also utilizing more is some of the different smart phone apps that are available now—PTSD Coach, for example. There is also a concussion app. There is cognitive behavioral therapy for insomnia, for example. Some of these things can walk them through treatment at home if they don't want to come in as frequently.

We are also looking at our staffing levels at all of our CBOCs, as well as the medical centers, and trying to work with each facility who is maybe having difficulty recruiting and maintaining staffing there by having individual discussions with our VISN mental health leads and with our staff at central office to see are there other things that we can be doing to recruit providers to those hard-to-recruit locations.

Mrs. KIRKPATRICK. Thank you. I yield back my time.

Mr. COFFMAN. Thank you.

Congresswoman Sinema, you are now recognized.

Ms. SINEMA. Thank you, Mr. Chairman.

Mr. Redlin, prior to my time serving in public office, I was a licensed clinical social worker. And during my time engaging in direct therapeutic relationships with consumers, I recognize how important it is to form that relationship with a client. Of course, equally important is the termination phase.

But what we heard from a number of vets and vets' family members today was the additional trauma that they experienced when finding an unexpected interruption of service delivery with their trusted therapist or provider.

What action does your office take—and perhaps Dr. Kearney can also answer, and Mr. Gardner as well. What steps are taken to help vets prepare for interruption of services or termination from their provider and transition to a new, appropriate provider?

Mr. REDLIN. Thank you, Congressman, and thank you for having me here today.

At the Tucson Vet Center, what I can say as far as trying to keep that continuity of care when we have possibly a counselor retiring or taking another position is get a heads-up on it and try and recruit, especially within. Just recently I can give you an example where we actually did a very good job with this and were able to bring on a counselor two months before when we knew he was leaving. Unfortunately, that is not the case a lot of times, so clients

are left feeling that they have no care or their care has been severely disrupted. But that is typically what we do at the Vet Center.

Were there other parts of the question I missed?

Ms. SINEMA. No, thank you.

Dr. KEARNEY. Thank you. One of the things that has been important that we have been rolling out across the VA is that every veteran within mental health would be assigned a mental health treatment coordinator, and that person, whether they were giving active treatment at that time or not, would be the person who makes sure that if they were transitioning, for example, to a substance use disorder treatment program, that they got in, they got started, things were not dropped.

It also helps with the creation of that seamless plan of care with the veteran. That treatment coordinator is responsible for discussing those plans. So when a provider would announce they are retiring or they are transitioning to another job, to be able to have discussions with the mental health treatment coordinator on next steps, and also for the provider to be able to have those discussions.

But another important thing that we are beginning to roll out within mental health is what we call behavioral health interdisciplinary programs, which is providing care by team, much like we do in our patient-centered medical home, the PACT, patient-aligned care teams, in which there are three to four people providing care to a patient. So they are all familiar with that patient so that the care is not going to be as much disrupted because that veteran may know the treatment team at hand. So we are hopeful that that will help address some of these different things that we have heard about this morning.

But also important is that the mental health treatment coordinator should make sure that the veteran gets the care he or she needs after that person leaves.

Ms. SINEMA. Thank you.

Dr. Scholten, you talked about the ability for a physician or perhaps a psychiatrist to prescribe a non-formulary drug, in particular a psychotropic drug, if the situation warrants. However, it appears from the testimony we heard from vets and Lance's father, Mr. Davison, that it is not perhaps the standard practice in many facilities.

Can you help us understand why different facilities have different formularies when those of us in the mental health profession know that psychotropic drugs cannot be easily substituted one for another, like an allergy medicine could be? And how can the VA system more effectively help prescribing physicians and psychiatrists understand the procedures to go off of the formulary when a situation warrants it, as in the case of Lance Davison and some of the other testimony we heard today?

Dr. SCHOLTEN. Thank you for the question, ma'am. You are correct in the fact that there are differences in formularies. I, unfortunately, can't speak to the rationale or the decision-making process that is made between each medical center. That would be a question for our pharmacy benefits group.

In regards to medications for mental health treatment, I would like to ask Dr. Kearney for some help with that.

Dr. KEARNEY. Certainly. One of the things that we advertise quite a bit to our mental health psychiatrists and other prescribers is the clinical practice guidelines that are available within VA and DoD which provide guidance on what medications would be best for what particular diagnoses. So that is one particular area that we provide guidance through our individuals on.

The other thing that we are beginning to roll out is the Psychotropic Drug Safety Initiative. We have heard concerns, and we are concerned as well and want to make sure that we are studying how these medications are prescribed, that we are helping prescribers get education as needed, that we are also helping to monitor improvements over time. So we are currently rolling this out across the nation to be able to better monitor at each facility how these medications are being utilized.

Ms. SINEMA. Thank you.

Mr. COFFMAN. There will be a second round if anybody has any additional questions.

Dr. Kearney, please describe the credentialing and licensing requirements under VA directors for psychologists and other clinicians responsible for administering C&P examinations that involve TBI determinations.

Dr. KEARNEY. So, we do have a licensing requirement——

Mr. COFFMAN. Can you speak more into the microphone, bring it a little closer to you?

Dr. KEARNEY. Oh, I'm sorry. So, there are requirements for any provider hired within the VA by discipline. So for psychologists, psychiatrists, social workers, et cetera. For psychologists, that includes that they have obtained a Ph.D. or a Psy.D., a doctorate of psychology, from an accredited institution, and that they have also fulfilled a formalized training program thereafter. We require that they have two years of experience before becoming full licensed psychologists within the VA. We have credentialing boards that review these, along with our—this includes human resources. It would include local chiefs of psychology reviewing that they meet each of these particular standards. If not, they are not allowed to be hired within the VA.

Mr. COFFMAN. So what happens if they are working with the VA and they lose their license, their state license?

Dr. KEARNEY. They would no longer be able to be employed with the VA. The requirement for working at the VA is that they maintain their licensure.

Mr. COFFMAN. That was certainly not the case in Montana.

Dr. Kearney, is the Repeatable Battery for the Association of Neuropsychological Status, the RBANS that was discussed earlier, that assessment tool, how commonly is that used by the VA for TBI rating determinations?

Dr. KEARNEY. That I could not answer. I would have to take that for the record, sir.

Mr. COFFMAN. Okay. Are there any consequences for officials failing to properly manage and supervise C&P examinations involving TBI?

Dr. KEARNEY. As with any concern that we have about an administrator or employee of our organization, we would be addressing that through our system of peer reviews, through reviews by our

human resources department, et cetera. I can't speak specifically to C&P.

Mr. COFFMAN. Is VA's MIND study considered trustworthy given the very small percentage of available veterans who participated?

Dr. KEARNEY. I will defer to Dr. Scholten on that.

Dr. SCHOLTEN. We can take that question for the record. I am familiar with the study. One of the study sites was actually at the Washington, DC, VA, but I would defer to our research colleagues to provide an analysis of the number of subjects and if that reached a statistical power to make those results generalizable.

Mr. COFFMAN. Ranking Member Kirkpatrick, any follow-up questions?

Mrs. KIRKPATRICK. Just one quick question.

Dr. Kearney, we heard from our first panel that out-sourcing to the local communities would improve care. So my question is two parts. First of all, do you have the ability to out-source? And if so, how are the decisions made when and if to do that?

Dr. KEARNEY. And, yes, we certainly can out-source. We have fee basis that we can do. We certainly do contracts with individuals and with the different organizations outside the VA. One of the examples of that is in response to the executive order. We had 24 community pilots with Health and Human Services in order to expand our services. So we are using that as models to expand to other areas as well in our rural communities.

But certainly at each facility, an administrator can look into fee basis. It is not based on a geographical limitation. It is based on a number of different things, including is the service even available at the VA, is there wait time for that service, do we need to go ahead and refer that out to the community.

So, yes, we are able to do this.

Mrs. KIRKPATRICK. Thank you.

I yield back.

Mr. COFFMAN. Congresswoman Sinema.

Ms. SINEMA. Thank you, Mr. Chair.

In his testimony in the first panel, Mr. Boales described receiving health care for his service-related injuries but not receiving a benefit or designation from that service-related wound. My understanding based on conversations with other veterans is that this is kind of an isolated incident.

In the cases in particular of military sexual trauma or military sexual assault in which the survivor often chooses not to report the incident at the time it occurs for reasons as we heard today from Mr. Boales, but for a variety of other reasons, what does the VA do or what can the VA do to ensure that the survivor does receive benefits at the time that he or she is able to report about that service-connected injury?

Dr. KEARNEY. And we are very concerned about our veterans who have experienced military sexual trauma and want to ensure that they get timely treatment to care. I can't comment about VBA's decisions to give disability for any particular person overall. So, I'm sorry, I will have to take that for the record.

Ms. SINEMA. I yield back.

Mr. COFFMAN. Thank you, Congresswoman Sinema.

Our thanks to the panel. You are now excused.

Today we have had the opportunity to hear from veterans and their families about the serious long-term consequences of traumatic brain injury. We heard about the continuing challenges veterans have in getting access to necessary services for TBI. We also heard from the VHA regarding the health care available to veterans with TBI. I expect the VA to use the discussions and issues heard today to improve upon services provided to our veterans.

I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks and include extraneous materials.

Without objection, so ordered.

Mr. COFFMAN. I would like to, once again, thank all of our witnesses and audience members for joining us in today's conversation.

With that——

Mrs. KIRKPATRICK. Mr. Chairman, I ask that the statement of Mr. Barber and Ms. Sinema's full statement be submitted to the record.

Mr. COFFMAN. So ordered.

Mr. COFFMAN. I would like again to thank all the witnesses and audience members for joining us today.

With that, this hearing is adjourned.

[Whereupon, at 2:45 p.m., the subcommittee was adjourned.]

APPENDIX

TESTIMONY OF

DEREK DUPLISEA, REGIONAL ALUMNI DIRECTOR

WOUNDED WARRIOR PROJECT

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

COMMITTEE ON VETERANS AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

ACCESS TO MENTAL HEALTH CARE AND TRAUMATIC BRAIN INJURY SERVICES: ADDRESSING THE CHALLENGES AND BARRIERS FOR VETERANS

APRIL 24, 2014

Chairman Coffman and Ranking Member Kirkpatrick:

Thank you for inviting Wounded Warrior Project to testify on a subject of great concern to us not only here in the Southwest, but across the country.

The focus of this hearing, "access to effective care and rehabilitation for traumatic brain injury and mental health conditions," is both a professional and personal concern for me. One week before my second deployment to Iraq was to end, a suicide bomber detonated her explosives five feet behind me and my platoon, leaving me and four others severely wounded, and effectively ending my 13-year U.S. Army career as a cavalryman, airborne-armor paratrooper, and scout. That life-changing date was August 16, 2006. I spent the next two years recovering from injuries that included a severe traumatic brain injury resulting from shrapnel that penetrated my helmet

and skull and lodged in the brain, a shattered right femur, a completely shattered right arm that was nearly amputated, burns, nerve damage, and PTSD. I've been working with and on behalf of wounded warriors since a few months after medically retiring from the Army in 2008.

We at Wounded Warrior Project are dedicated to a vision that this generation of wounded veterans should be the most successful and well-adjusted in our country's history. We provide warriors a wide range of assistance through programs that include physical health and wellness programming, re-engagement with peers, job-training and employment assistance, overcoming mental health issues, and – for those with severe TBI – assistance in living more independently. We are reaching nearly 50,000 warriors across the country. But many more need help, particularly given the toll of invisible wounds.

Our Wounded Warriors

WWP has worked with RAND to survey the warriors with whom we work on an annual basis, and those data are illuminating. Our most recent annual survey of July 2013[1] -- reflecting the experience of some 14 thousand respondents – found the three most commonly reported health problems were PTSD (75.4%), anxiety (73.9%), and depression (68.8%). More than 44% of respondents had experienced traumatic brain injury. Almost 60% of injuries resulted from blasts, including IED's, mortar, grenade and bombs.

More than half of respondents rated their overall health as only fair or poor, with 54% stating that their health limits them a lot in undertaking vigorous activities. More than 25% said they need the aid and attendance of another person for more than 40 hours weekly because of their injuries or health problems. Military experiences are still affecting many in seriously adverse ways. More than two-thirds reported having had a military experience that was so frightening, horrible or upsetting that they had not been able to escape from the memories or effects. More than 48% reported having trouble concentrating, about 43% had little interest or pleasure in doing things, and more than 42% said they had sleep problems. Overall, the survey results indicate that for many, the effects of mental and emotional health problems are even more serious that the effects of physical problems, with more than 25% reporting being in poor health as a result of severe mental health conditions.

While the survey showed that many wounded warriors have ongoing health care needs, they sometimes have difficulty getting that help. Some 55% reported that they had seen a professional to get help with issues such as stress, substance-use, emotional problems or family problems. But 34% did not get the care they needed. The reasons included inconsistency or lapses in treatment (41%), feeling uncomfortable about the resources available to them through DoD or VA (32.5%), concern about future career plans (28%), feeling that they would be considered weak (24.6%), and believing that they would be stigmatized by peers or family

[1] Franklin, et al., 2013 Wounded Warrior Project Survey Report, (July 2013).

(22%). Respondents reported the top resource they had used since deployment to address their mental health problems was talking with another OEF/OIF veteran (56.7%).

Mental Health Care

With such numbers, access to mental health care is vital. But "access" alone is only one dimension. That care must, of course, also be timely and effective.

I can attest myself to having benefitted from VA mental health services at the Tucson VAMC. But our regional and national experience indicates there is wide variability from facility to facility. The experience of getting mental health services at Phoenix, for example, is very different from that at Tucson. Nationally, VA did increase mental health staffing last year, but we see evidence that the allocation of those new employees did not meet the staffing needs of many VA facilities, and that VA's overall staffing target was too low. VA also took steps to address veterans' long waits to be seen for initial mental health appointments. As a result, VA appears to have improved its scheduling of initial appointments to meet its 14-day performance requirement. But there's a difference between being "seen" for an initial assessment and actually starting treatment, which may not occur for weeks. (Some veterans in Arizona have reported still waiting months for mental health care.) For warriors whose training is to "soldier on" and "tough it out," asking for help – especially for mental health care – is a long-delayed last step. Understandably, warriors who are at the end of their rope and finally seek help at a VA medical facility often experience deep frustration and even despair if they are told to wait six weeks or longer to begin therapy. Deferred treatment can set the stage for potentially tragic outcomes.

Despite VA's efforts at improvement, and the hard work of dedicated, highly professional clinicians at many VA facilities, we still see evidence of an understaffed system that is under stress, with instances (compiled from the experiences of my co-workers across the country) of --

- Veterans who need individual therapy being pushed into group therapy without that earlier support (or taking the group option because the wait time for the individual therapy they had requested is too long or therapists are not available);
- Lack of follow-up care after a time-limited treatment program;
- Failure to provide needed treatment proactively on a weekly or biweekly basis, and instead having to react when the veteran's condition deteriorates to a point of crisis;
- Facilities not offering warriors the option of fee-basis (community) mental health treatment even when the earliest VA appointment slot is many months away;
- Veterans being unable to schedule after-hours' appointments to accommodate work or school because the number of such slots is so limited;
- Facilities that don't provide trauma-treatment.

Just this January, we also attempted to examine the experience of warriors with whom we work who have experienced military sexual trauma. We learned that –

- Of those respondents who had experienced military sexual trauma, 85% had developed anxiety, 79% suffered from depression, and 70% had developed PTSD;
- Only 25% of those who sought care at VA for a health condition related to MST had had any contact with an MST coordinator;
- Of those who sought VA care for an MST-related condition, 49% reported they had had difficulty accessing that care;
- Only 29% of those who received care for an MST related condition reported that they found it effective.

The survey respondents' general comments regarding their experiences with VA mental health services included the following:

- "The VA system lacks available one-on-one counseling. They had only group, and even that was not properly staffed."
- "They try to quickly get you in and out, never truly listening to what I am telling them about my body. Then they want to slap a 'band aid on a broken bone.'"
- "The therapist I did see had limited times. Then I called the Vet Center (45 minutes away from me) and they have a MST group. However, they meet in the evenings and do not provide child care."
- "My 'shrink' is wonderful, but he does not have the time to be able to provide counseling, he is too far away for me to get to easily, and it is usually a 6-8 week wait from me calling for an appointment to actually getting to see a doctor."

We don't suggest that these are simple problems. In fact, they are multi-layered. But part of the prescription, in addition to more staffing, would be to develop better tools to assess how VA mental health care is delivered. VA has some mental-health performance metrics; but they don't assure that patients are actually getting better since none measure mental health patient outcomes. It is just not good enough to say that VA is "seeing" high percentages of veterans for mental health conditions when treatment is sporadic or is limited to provision of medications – as it is for too many of our warriors. Access to timely, effective treatment should be the norm, not simply a distant goal.

Traumatic Brain Injury

Overall, VA faces challenges in meeting veterans' mental health needs, though it emphasizes that mental health care remains a high priority. In contrast, VA proposes to diminish the funding it devotes to traumatic brain injury care under the FY 2015 budget, citing a decline in the number of TBI cases. I consider myself to be fortunate to have received excellent care for the TBI I sustained in Iraq. But a proposal to diminish TBI funding is troubling, given the experience of other warriors in Arizona, who have reported difficulty in getting a diagnosis of traumatic brain injury from VA, and -- even with a diagnosis of moderate TBI -- several have reported to us that

they encountered difficulty in getting treatment (being told, for example, that "there's nothing we can do for you").

VA's projection that it will need less funding for TBI care fails to take account of an even more fundamental point – that Congress enacted bipartisan legislation in 2012[2] to improve long-term VA rehabilitation of veterans with traumatic brain injury. That law requires VA to put two important policies in place. First, it directs VA to provide veterans who have moderate and severe TBI with rehabilitation of ongoing duration to sustain, and prevent the loss of, functional gains. Second, it calls for VA to provide ANY community-based services or supports that may contribute to maximizing that veteran's independence. Shortly after the law's enactment, however, VA took the position that it was already in compliance and that no further action was needed. The fact is, VA is NOT meeting the law's requirements!

Following up on reports from caregivers and warriors, Wounded Warrior Project initiated a survey in February of more than two thousand caregivers of warriors with severe and moderate TBI. We found no evidence that VA has implemented the law or that the practice patterns that the law aimed to change have been altered to any measurable extent.

It remains common for warriors to have TBI rehabilitative services discontinued by VA either after a set number of treatment sessions (or days of care) or on the basis of a judgment that the warrior has "plateaued." Caregivers reported that efforts to have VA provide services had mixed results. Often those requests were denied, frequently (for 40% of respondents) with no explanation given. Warriors and caregivers are apparently often left to their own devices to continue the warrior's rehabilitation, with two-thirds of respondents indicating that VA rarely if ever contacts them (though a handful have weekly communication). The upshot is that 25% are paying out-of-pocket for services that VA is not providing. One-quarter of those pay more than $300 monthly out-of-pocket to provide rehabilitative services.

While some caregivers did express satisfaction and appreciation for VA's services and clinical professionalism, the responses predominantly reflected frustration:

- *"...a lack of understanding of how a veteran with severe tbi will need some ongoing rehabilitation to maintain gains..."*
- *"Service providers are overloaded and [there is] lack of continuation of care..."*
- *"The stance of VA has been that if the warrior sustained injury more than 18 months ago cognitive therapies will not benefit him (which is absolutely false)"*
- *"VA gave up on him. But I didn't. I kept teaching him to count & read & write. I took him to the gym and got him lifting weights until he could raise his hand above his head & walk for 20 minutes without falling. I looked up nutrition and fed him to get him to gain back some of the 50 pounds he lost. I'm the one who does everything for him."*

[2] Public Law 112-154, sec. 107.

- *"...[T]he lack of help from VA takes its toll on my husband and our family..."*

While the law calls for VA to cover a broad spectrum of services for veterans with moderate to severe TBI -- including non-medical services -- to help the warrior achieve maximum independence, VA policy provides no guidance on what services it will cover. Caregivers are understandably deeply frustrated about that, even as they cite a wide range of services and supports that would be helpful, and that in some instances they pay for on their own.

This void in policy direction and guidance regarding TBI-rehabilitation has clearly frustrated congressional efforts to improve the rehabilitation of warriors with TBI. It has also resulted in what appears to be wide disparity from facility to facility in what services are provided or authorized. (WWP is aware, for example, of instances where patients with similar levels of brain-injury impairment receive vastly different levels of support, apparently reflecting budget limits set by individual facilities.) VA could easily avoid this ambiguity regarding coverage and the disparate levels of coverage. In comparable circumstances, VA has published clear policy on what benefits and services it will provide. To illustrate, VA regulations promise a comprehensive package of well-defined benefits to even a non-service connected veteran who lacks special priority but who has enrolled for VA care.[3] Similarly, with respect to mental health care services, the Veterans Health Administration has published a uniform mental health services handbook that sets forth the array of services VA facilities are expected to provide.[4] It is troubling that warriors who have sustained profoundly life-changing brain injuries resulting from weapons-fire and IEDs have no comparable VA roadmap, and that the VA services and supports they may receive depend on the happenstance of geography or widely disparate clinical or administrative practices.

The bottom-line is that warriors and caregivers are still waiting for implementation of an important law which provides, in essence, that VA's responsibility to further the veteran's rehabilitation does not end when he or she is able to return home. For many, the rehabilitative journey only starts at that point.

Through our Independence Program[5], Wounded Warrior Project is working today with about 140 warriors who have severe brain injuries to provide them the very kind of community supports VA should be providing under the law. We certainly intend to continue to assist these warriors in becoming as independent as possible (and to increase the number we will help), but also want VA to meet its obligations under law.

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[3] 38 C.F.R. sec. 17.38.

[4] Veterans Health Administration, "Uniform Mental Health Services in VA Medical Centers and Clinics, VHA Handbook 1160.01 (Sept. 11, 2008). accessed at http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1762

[5] See http://www.woundedwarriorproject.org/programs/independence-program-and-long-term-support-trust.aspx

We urge the Subcommittee to press VA to implement this important law, and look forward to working with you to improve both the care of veterans with mental health needs and those with traumatic brain injury.

Witness Testimony of Ms. Ariana Del Negro & Charles R. Gatlin, CPT, USA (Ret).

Mr. Chairman and Ranking Member Kirkpatrick, thank you for allowing us the opportunity to participate in this forum addressing the challenges and barriers Veterans and their families face when accessing mental health care and traumatic brain injury (TBI) services within the Veterans Administration (VA) system. My name is Ariana Del Negro. My husband, Charles Gatlin, CPT, USA (Ret) and I are here today to discuss the shortcomings of the compensation and pension (C&P) process as it relates to evaluating residuals of TBI and to propose initial suggestions to narrow outstanding gaps. Effectiveness of treatment services for TBI is highly contingent on establishing a foundation of trust between patient and provider.[1] Because C&P is often the first clinical encounter a Veteran has with the system, we believe interactions with professionals during the C&P process will influence the degree to which a Veteran will actively seek or engage treatment services within other parts of the VA system.[2] Thus, it is imperative that the C&P process operate fluidly and productively so as not to dissuade Veterans from seeking much needed care.

While this testimony is based on our experience with the Fort Harrison VA in Helena, Montana, there is evidence that the gross malpractice and undercutting of the Veteran and his/her family that we have witnessed is indicative of policies and procedures routinely endorsed within the local system and may even reflect current practice at many VAs throughout the nation, with potentially catastrophic consequences for hundreds, if not thousands, of Veterans and their families. Using our experience as a case study, we intend to identify critical gaps and barriers related to the handling of TBI claims that must be addressed at both institutional and policy levels to protect the long-term interests of the Veteran and his/her family.

Military experience

My husband, the Scout/Sniper and Reconnaissance Platoon Leader of his Infantry Battalion (25th Infantry Division, Schofield Barracks, Hawaii) deployed in August 2006 with his unit to the northern area of Iraq. He was awarded a Purple Heart for events that occurred on September 28, 2006: while dismounted outside his FOB in Kirkuk, a vehicle-borne improvised explosive device detonated less than 20 yards from where he was standing. His injury and loss of consciousness were witnessed and he was subsequently medevac'd to Balad Medical Center where he was diagnosed with a closed-head TBI. As detailed in my previous testimony delivered on October 17, 2007 to the Senate Committee on Veterans Affairs (available in the congressional record for reference), upon his return to Hawaii, we faced numerous obstacles in seeking appropriate medical care and rehabilitative services for his injury. Eventually, we were fortunate enough to obtain access to professional and coordinated rehabilitative care through the C5 program at Balboa Navy Medical Center working in conjunction with civilian services offered by the Sharp Institute's Community Reintegration Program in San Diego, California.

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[1] Spelman FJ, Hung SC, Sealk KH, Burgo-Black AL. Post-deployment care for returning combat veterans. *J Gen Intern Med*. 2012;27:1200-1209.

[2] Elbogen EB, Wagner HR, Johnson SC, et al. Are Iraq and Afghanistan veterans using mental health services? New data from a national random-sample survey. *Psychiatr Serv*. 2013;64:131-141.

Sharp taught my husband invaluable compensatory strategies to overcome his limitations—compensatory strategies he still employs to this very day. The rehabilitative process incorporated patient education on the nuances of the injury, including the fact that some symptoms may never resolve. We also obtained helpful information regarding the scope of neuropsychological testing required to document impairments and monitor progress following TBI. Importantly, we learned that simple diagnostic tests were not sufficient to adequately capture objective evidence of deficit.

Over the course of three years, and in accordance with DoD/VA guidelines for the management of concussion and mild TBI,[3] my husband underwent three comprehensive batteries of neuropsychological testing administered by highly qualified and appropriately licensed neuropsychologists—specialists described in a 2010 Veterans Health Initiative on TBI as "the key player in diagnosing cognitive impairments and emotional and behavioral sequelae of TBI."[4] At each appointment for testing, my husband and I were interviewed together and individually by the neuropsychologists; we were also asked to complete questionnaires that served to compare his premorbid vs post-injury functioning. In addition, neuropsychological evaluation required my husband to undergo hours of other testing using highly sensitive and specific tests to gauge the degree of his deficits. Neuropsychological testing is a labor-intensive process and the results of the testing require careful and detailed analysis which can take weeks to complete in order to ensure a fair assessment.

In each of the follow-up appointments with the neuropsychologists, we were told that his test results documented deficits in multiple areas, with each battery of testing showing objective clinical evidence of deficit that remained consistent across batteries. Following his final battery of testing in 2009, the neuropsychologist noted:

> *The results of this evaluation indicates that CPT Gatlin continues to experience impaired information processing speed, fine motor dexterity/speed, and impaired pure motor speed. He displays executive dysfunction and impaired visual attention. Relative to the neuropsychological assessments completed in 2006 and 2007, there appears to be an overall stability of dysfunction in the areas noted above.*

Because my husband's progress had not improved since his previous evaluation, the neuropsychologist concluded: "there is reasonable degree of certainty that three years post-injury his deficits are likely to be stable and permanent." And based on those findings, the Army medically retired (PDRL) my husband, inclusive of a 70% disability rating for his residuals of TBI.

Failures and contradictions at Fort Harrison

It was our intimate familiarity with the evaluation protocol for residuals of TBI that alerted us to the gross misconduct we would experience at the hands of the Fort Harrison VA. On August 24, 2011, my husband and I drove more than two hours from our home to the Fort Harrison VA for a C&P

[3] Management of Concussion/mTBI Working Group. VA/DoD clinical practice guideline for management of concussion/mild traumatic brain injury. *J Rehabil Res Dev*. 2009;46:CP1-68.
[4] Department of Veterans Affairs, Employee Education System. Veterans Health Initiative. Traumatic Brain Injury. Independent Study Course Released: April 2010. [pg. 141] Accessed 4/21/2014 at: http://www.publichealth.va.gov/docs/vhi/traumatic-brain-injury-vhi.pdf

appointment with Robert Bateen, PhD, a clinical psychologist tasked with evaluating my husband's residuals of TBI. Instead of beginning the appointment with a comprehensive interview as we had been accustomed to, our initial exchange with Dr. Bateen was brief and I left the room after only a few minutes so the remainder of the examination could be conducted. Instead of at least the 2-4 hours it typically takes to conduct neuropsychological testing, my husband emerged from his appointment no more than 60-90 minutes later.

The short duration of the appointment and the fact that neuropsychological tests were not performed led us to believe that evaluation for TBI residuals was not extensively or sufficiently conducted. We sought immediate clarification from the VBA as to whether the reason for not administering the tests was because the examiner would use the results of my husband's prior neuropsychological testing as the basis for his conclusions. We insisted that if the results were not going to be used appropriately, my husband should be referred for proper neuropsychological assessment. We brought our concerns to the attention of VBA as soon as possible with the precise intent of avoiding a long, drawn-out appeals process. Unfortunately, our petition fell on deaf ears and my husband was assigned only 10% for residuals of TBI (VASRD 8045). A 10% rating is assigned to patients with "subjective" complaints that cannot be detected by objective clinical testing. My husband was not being subjective in any of his complaints and the mere suggestion that there was no basis for these symptoms was perceived by my husband as questioning his integrity. Our repeated requests for additional neuropsychological testing were denied.

Several justifications were offered for assigning the low percentage and for denying referral. Justifications for assigning the low percentage included the following:

1) **We were told that it was of greater benefit to my husband to rate his residuals individually rather than rate them collectively under VASRD 8045.** However, the two symptoms which have the most significant impact on my husband's instrumental activities of daily living—fine motor skill deficits and depth perception—were not accounted for.

2) **The examiner concluded that based on the screening test he used, there was no objective evidence documenting cognitive deficits and that if any deficits did exist, they were likely secondary to a diagnosis of post-traumatic stress disorder (PTSD) and not related to his TBI.** In a subsequent records review, Dr. Bateen did acknowledge "that a diagnosis of cognitive disorder, NOS, by history, would be acceptable," yet, he contradicted himself in the very same record entry, stating: "I would note that cognitive symptoms appear to be mild, *if present*, and do not appear to be at a level that significantly impacts functioning" (emphasis added). In his summation of the findings, Dr. Bateen again contradicted his suggestion that there was established evidence of deficit, concluding: "It should be noted that there was a complaint of mild memory loss, attention, concentration, and executive functions *without objective evidence on testing*. Again, concentration difficulties could be best explained in terms of the Veteran's post-traumatic stress disorder symptoms" (emphasis added).

3) **The examiners stated that there was "evidence that the Veteran's symptoms are improving."** However, they did not test him using the same tests as before, leaving no consistent yardstick with which to conclude whether these symptoms had in fact improved. Moreover, the test they did use was interpreted incorrectly (described below). The rationale used to justify the examiners' conclusions were based on nonspecific mention of medical literature suggesting potential continuing improvement after one or two years. When my husband was seen at Fort Harrison, he was 5 years post-injury and his 3-year assessment noted no further improvements. There is a bounty of evidence-based literature, including literature produced by the VA, stating that some symptoms of persistent-post-concussive syndrome can be permanent. The VA's predischarge document for *Traumatic Brain Injury (TBI) Evaluation: Comprehensive Version* notes: "Some sequelae of TBI may be permanent."[5]

4) **My husband's progress notes contained a statement that because he was attending graduate school, his complaints could not be that disabling.** Such an errant assumption is irresponsible, unsubstantiated, and discriminatory, not only to my husband, but to all Veterans who have worked hard to continue their educations in the face of adversity. It negated all of the hard work my husband dedicated to his schooling. He is registered with the disability office at the University of Montana and the limitations of his injury require significant discipline and profound effort to meet the demands of his schooling. He should be commended, not penalized for his accomplishments.

The VA's justifications as to why our requests for referral to appropriate neuropsychological testing were denied included the following:

1) **My husband's prior neuropsychological test results suggested stability of dysfunction and therefore further testing was not deemed required.** It remains unclear why the examiners elected to agree with the opinion of the previous neuropsychologist regarding stability of dysfunction, yet failed to honor the overall results from that testing when conducting their own assessments.

2) **The VA does not require a full battery of neuropsychological testing to evaluate residuals of previously diagnosed TBI "because the rating of residuals is not based on the quantum of damage, but rather how the veteran applicant is functioning at the time of his or her evaluation in the areas of home, education, or occupation."** While my husband has been able to attend school, I will be candid: his home life and relationships with other family members are far from functional. In his brief meeting with my husband, Dr. Bateen failed to sufficiently inquire as to those facets of my husband's life, nor did he ask me, his primary caregiver; as

[5] Traumatic Brain Injury (TBI) Evaluation: Comprehensive Version. [under 'definition of traumatic brain injury'] Accessed 4/21/2014 at http://benefits.va.gov/PREDISCHARGE/DOCS/disexm58.pdf

established in the medical community, the primary caregiver is the individual with the greatest insight into their loved one's degree of disability.[6]

3) **The VA does not employ or contract with neuropsychologists in the state.** At the time my husband was evaluated at Fort Harrison, we were informed that the system did not have a neuropsychologist on staff who was certified to conduct C&P examinations. We were also told by the VBA office that they could not refer us to any local neuropsychologists because they did not contract out with any and could only do so if those providers received training that would authorize them to conduct the C&P examination. Of the 71 DBQs the VA has drafted, 8 are not available for use by private providers, including the DBQ for TBI.[7] (I refer the reader to the written testimony of Tana Ostrowski, COTA/L, CBIS, Community Bridges, Rehabilitation Institute of Montana, for further insight as to the extent Fort Harrison has elected to partner with community resources).

4) **The VA does not want to pay for it.** Addressing my husband's case specifically, Alison N. Cernich, PhD, Deputy Director, Defense Central Office, Mental Health Services, stated:

> *Veterans Health Administration performs over a million Department of Veterans Affairs disability evaluations yearly. To mandate a repeat full psychological battery for 'residual' functional evaluations for every veteran who claims any cognitive impact from TBI would have a large negative impact on the Veterans Health Administration and Veterans Benefits Administration. The sheer cost and delay in obtaining such a large number would divert money needed for benefits, delay administration of claims even further, and divert providers from actual treatment.*

Two points are worthy of mention here. First, if the VA did not want to pay for neuropsychological testing for my husband, why not honor his previous test results—test results that the VA acknowledged represented his current level of functioning? Second, and most telling, is the recent revelation that Fort Harrison has suddenly changed their practice and are now referring Veterans to qualified neuropsychologists for C&P examinations, despite these alleged financial burdens.

Naked Truths & Consequences: VA Evaluations and Ratings for Residuals of TBI at Fort Harrison

- ***VA places greater importance on saving time than thoroughness; makes unreasonable demands for scheduling***

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[6] American Academy of Clinical Neuropsychology. American Academy of Clinical Neuropsychology (AACN) practice guidelines for neuropsychological assessment and consultation. *Clin Neuropsychol.* 2007;21:209-231

[7] Veterans Benefits Administration. Disability Benefits Questionnaires, Frequently Asked Questions. Accessed 4/20/2014 at http://www.benefits.va.gov/compensation/dbq_FAQs.asp.

VHA Directive 1603 regarding disability evaluations acknowledges "...the importance of a thorough evaluation to the Veteran or Servicemember in terms of eligibility for future benefits..."[8] Specifically, in the case of TBI, the aforementioned predischarge document serves as a means to collect clinical data to be used by both the military and the VA for their disability assessments. Drafted by the VA, the very first line of the form's narrative reads: "The potential residuals of traumatic brain injury necessitate a comprehensive examination to document all disabling effects."[9] However, according to Dr. Cernich, again addressing my husband's case: "A C&P exam is conducted in a very structured manner according to the Veterans' Benefits Administration legal needs. The exam is to be part of a quick and accurate response considering that over one million applications for disability benefits are received by VA each year."

Efforts to streamline the claims process into a one-size-fits-all approach have ended up working against the individual Veteran. Particularly with respect to TBI, the nuances of the injury vary significantly from patient to patient, and such nuances affect degree of disability and quality of life differently. Evaluating the residuals of TBI mandates an individualized and focused approach. A better balance is needed that offers increased efficiency without adversely affecting efficacy.

In addition, the system's goal of setting short deadlines to meet national standards for which appointments must be made and completed is not realistic. I recognize the reasoning behind trying to move Veterans through the system quickly. However, patient demographics of Veterans have changed in recent years. The profound influx of young men and women requires a different approach to meet the needs of today's generation of Veterans.

I refer to the Fort Harrison VA as a system that expects me and my husband to dance for them, rather than *with* them. The expectations placed upon any Veteran and his/her family to navigate through the C&P process are unreasonable. And, in cases when a Veteran has residual and disabling symptoms from TBI, such burdens can be even more profound. In Montana, and in other areas of the country, the main VA can be hundreds of miles away from where a Veteran and his/her family live. Attending appointments at distant locations (and sometimes at ridiculous early hours) requires significant planning; some families have to take off from work, find child care, and incur significant out-of-pocket costs that are not routinely reimbursed by the VA.

In our case, my husband was in school. The nature of his injury required additional effort for his schooling; missing classes would set him back academically. Instead of recognizing his limitations, the schedulers made requests that were entirely inappropriate. I had to educate them that part and parcel of his injury is the effect that fatigue has on his symptoms; thus, it was not possible for us to drive to Helena in the morning, attend a laborious appointment, and drive back to Missoula in time for him to

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[8] Department of Veterans Affairs. Veterans Health Administration. VHA Directive 1603. "Certification of clinicians performing VA disability evalutions" [sic] April 7, 2013. Accessed 4/21/2014 at: http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1643

[9] Traumatic Brain Injury (TBI) Evaluation: Comprehensive Version. Accessed 4/21/2014 at http://benefits.va.gov/PREDISCHARGE/DOCS/disexm58.pdf

attend class. I also had to frequently remind them that I had commitments to my job and could not always meet their scheduling demands. I had to emphasize that it was not an option for him to go by himself; as his caregiver, I was the one uniquely positioned to be able to communicate his limitations and current functioning to the examiners.

It was tremendously frustrating to have to relay facts about the injury that should have already been available throughout the system. Seven years have passed since the release of multiple reports and calls for educational initiatives addressing TBI. There is little excuse for why those within the system who have regular interactions with wounded Veterans remain oblivious to the nuances of one of the signature wounds of current conflicts.

- ***C&P examiners unqualified and frequently practice outside the scope of their expertise; certification programs are insufficient***

In our own experience with the C&P process at Fort Harrison, several C&P examiners were neither properly licensed nor qualified to competently assess degree of disability across a host of specialized medical conditions. In my husband's case, they tasked a clinical psychologist without proper neuropsychological training to evaluate residuals of TBI related to cognition. It is as if the VA sends a patient with cancer to an eye doctor for assessment.

Our concerns are not conjecture; they are founded on evidence-based principles and they have since been independently validated by the State of Montana Board of Psychology. My husband and I filed a grievance against Dr. Bateen with the Board, asking them to determine whether Dr. Bateen had practiced outside the scope of his expertise when evaluating and determining the degree of cognitive, deficits attributed to my husband's TBI. In its amended notice dated November 8, 2013, the Board stated that "The act of examining the cognitive aspects of brain behavior changes due to traumatic brain injury is by definition engaging in clinical neuropsychology." Therefore, they asserted that Dr. Bateen "created an unreasonable risk of physical or mental harm or serious financial loss to Gatlin, when Licensee [Bateen]:...offered opinions in a specialized area of psychology for which he was not qualified." Our case was not unique. At Dr. Bateen's own admission, he had previously conducted these type of examinations on "hundreds" of patients.

In all of his C&P appointments for his residuals of TBI, my husband never saw a single M.D. In addition to his evaluation by Dr. Bateen (PhD), he was seen by a physician assistant and a nurse practitioner. The latter was asked to evaluate my husband's fine motor skill deficits. In her notes, she acknowledges the profound deficits in function, but states that she "is unable to explain" the reasoning behind such deficits. Based on her report, and despite comprehensive assessment and diagnosis of motor skill deficits secondary to my husband's TBI while in service (results of testing for my husband's fine motor skills in his left hand were impaired below the 1st percentile), the Fort Harrison VA denied service connection for this complaint on the basis that "the medical evidence of record fails to show that this disability has been clinically diagnosed." We argue that this disability could not be clinically diagnosed by the VA examiner because the examiner was not qualified or trained to diagnose it.

In according with VHA Directive 1603, clinicians who conduct C&P examinations for residuals of TBI are required to complete the CPEP Traumatic Brain Injury training module and complete the post-test.[10] While access to the content of the training module is not available to the public, the post-test for the specific module is available online at: https://www.vesservices.com/secure/va/CPEP_Traumatic_Brain_Injury.pdf. Having worked in the world of continuing medical education for more than 12 years, I can testify that the post-test questions are resoundingly weak, do not address evidence-based practice, and fail to meet the rigorous standards of demonstrating that new acquired knowledge will translate into improved practice performance. Outcomes studies to definitively measure the true efficacy of CPEP training modules should be mandatory.

- ***VA examiners use inappropriate tests, misinterpret test results, make unfounded clinical conclusions, and fail to uphold the standard of care***

According to the VA/DoD Clinical Practice Guideline For Management of Concussion/mTBI issued in 2009, "Neuropsychological testing should only be conducted with reliable and standardized tools by trained evaluators, under control conditions, and findings interpreted by trained clinicians."[11] The highly sensitive and specific tests used by the neuropsychologists in their 2006, 2007, and 2009 evaluations of my husband included select subsets of the Wechsler Adult Intelligence Scale-III (WAIS-III), Million Behavior Medicine Diagnostic (MBMD), Conners Continuous Performance Test-II (CPT-II), and the Wisconsin Card Sorting Test-4 (WCST-4), as well as a number of tests to measure fine motor skill function. At the Fort Harrison VA, only one test—the Repeatable Battery for the Association of Neuropsychological Status (RBANS)—was used. Moreover, it was used inappropriately and the test results were interpreted incorrectly.

RBANS is a brief screening test originally developed to screen for dementia in the elderly. It has inherent limitations in its use for evaluating executive functions, category fluency, and motor responses, and it is not adequately sensitive to milder forms of brain dysfunction.[12] All of these limitations are precisely the areas where deficits were noted in my husband's prior neuropsychological testing. Therefore, and as ruled by the Montana State Licensing Board of Psychology:

> *Because Gatlin's medical history established he had a TBI and had significant deficits three years post injury, it was improper for Licensee to use RBANS as the testing instrument to determine Gatlin's cognitive functioning and to use it [as] the basis to formulate his evaluation conclusions. Therefore, the Licensee's assessment was insufficient to provide appropriate substantiation for his findings.*

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[10] Department of Veterans Affairs. Veterans Health Administration. VHA Directive 1603. "Certification of clinicians performing VA disability evalutions" [sic] April 7, 2013. Accessed 4/21/2014 at: http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1643

[11] Management of Concussion/mTBI Working Group. VA/DoD clinical practice guideline for management of concussion/mild traumatic brain injury. *J Rehabil Res Dev.* 2009;46:CP1-68.

[12] Lezak MD, Howieson DB, & Loring DW. (2004). *Neuropsychological assessment* (4th ed.). New York: Oxford University Press. [pg 697]

Despite the Board's conclusions, Dr. Cernich, in her statement issued on behalf of Dr. Bateen, states: "I conclude that Dr. Bateen appropriately conducted a C&P residual examination with recommended screening measure that has been validated for use with individuals with TBI." However, the paper she references the reader to substantiate her conclusion is a study that discusses the utility of the RBANS in *moderate and severe TBIs, not injuries classified as mild.* In describing the limitations of their study, McKay, et al write: "The current sample was comprised of individuals from a Midwest treatment centre who had sustained moderate to severe brain injuries with a large range in time since injury. *Therefore, the generalizability of these results may be limited and thus research would benefit from replication in other populations with differing injury and demographic characteristics*" (emphasis added).[13]

Dr. Bateen noted my husband had an Attention score of 85 on RBANS and initially concluded that that score was in the average range. However, the Montana State Licensing Board of Psychologists concluded that it was not average, noting "It is in the low average range at the 16th percentile. This score is one standard deviation below the mean, which is a level of performance commonly viewed as impaired by clinical neuropsychologists." Of note, the study by McKay, et al reported that the subsets comprising the RBANS Attention Index correlated strongly with the comparable WAIS-III counterparts. If the McKay paper is intended to serve as a seminal study justifying the actions of VA clinicians to use RBANS, then it would have behooved Dr. Bateen to compare the deficits he noted in the attention index with my husband's score of the comparable WAIS-III measure also documenting deficits.

In a later record entry into my husband's record, Dr. Bateen acknowledges the significance of my husband's attention score on RBANS, adding that a diagnosis of a cognitive disorder, NOS "would be appropriate" However, he concludes that any cognitive difficulties were secondary to my husband's PTSD and not to his TBI. Although beyond the scope of this testimony, the economic attractiveness of attributing cognitive deficits to PTSD, rather than to TBI is well established. Moreover, it can have significant repercussions in the treatment setting, as studies have shown that a large proportion of Veterans diagnosed with PTSD do not seek mental health care,[14] and of those that do, there are high attrition rates within programs, including those for PTSD-related cognitive impairment.[15] As summarized by the Montana Board, "Incorrectly categorizing Gatlin's attention score and erroneously ascribing it to PTSD and generally failing to address or reconcile Licensee's findings with those of the previous evaluations are examples of Licensee's failure to conduct the assessment in accordance with the applicable standard of care."

There is evidence to suggest that the use of RBANS is not limited to the Fort Harrison VA. According to Dr. Bateen, "This test had been used at the VA in Texas for a screening tool to conduct the C&P exams." What is uncertain is the degree to which RBANS is being used within the VHA system for diagnostic and treatment purposes. Therefore, and especially since the practices of Dr. Bateen were endorsed by the

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[13] McKay C, Casey JE, Wertheimer J, Fichtenberg NL. Reliability and validity of the RBANS in a traumatic brain injured sample. *Arch Clin Neuropsychol.* 2007;22:91-98.

[14] Tanielian TL, Jaycox LH, eds. Invisible wounds of war: psychological and cognitive injuries, their consequences, and services to assist recovery. Santa Monica, CA: RAND Corporation; 2008.

[15] Seal KH1, Maguen S, Cohen B, et al. VA mental health services utilization in Iraq and Afghanistan veterans in the first year of receiving new mental health diagnoses. J Trauma Stress. 2010;23:5-16.

administration at Fort Harrison, including Christine Gregory, Director, VA Montana Health Care System, and Gregory Normandin, MD, responsible for oversight of C&P examiners on staff, and because Dr. Cernich asserted that the use of RBANS was appropriate, a thorough audit of at least the Fort Harrison VA, if not all VA systems, is warranted to determine the frequency of using RBANS and whether those tests were properly administered and interpreted.

- ***Examiners make contradictory concluding statements, lack of parity between examiners allow raters to cherry pick information***

Noted above as it relates to my husband's claim, there were instances in which Dr. Bateen contradicted his own conclusions, including instances where disagreement occurred in the exact same record entry relating to the presence or absence of a cognitive disorder, NOS. This practice is not reserved to Dr. Bateen alone. In another instance, Beverly McGowan, APRN-BC, concluded in one record entry that her "Clinical examination notes associated symptoms of chronic headaches, mild speech impairment, vertigo, fine motor skills that are more likely than not related to the veteran's TBI." Three months later and without reexamining my husband, she asserts in his record that "review of the claim file medical records provides evidence that the veteran's symptoms are improving..."

The VBA is adamant that raters are not medical professionals and that they rely exclusively on the medical opinions of its VHA examiners. Addressing the facts of my husband's case specifically, Janice S. Jacobs, Deputy Undersecretary for Disability Assistance states that "Generally, the VA most often relies upon the VAE [VA examination] in determining not only entitlement to service connection, but also the severity level associated with the conditions claimed." Therefore, consistency of opinion is a necessity and opinions by C&P examiners must be written in a manner which can be properly interpreted by a layman. The system offers specific language that examiners must use when writing opinions that is intended to aid the raters in their decision making.[16] Such statements include, but are not limited to: "More likely than not;" "At least as likely as not;" "Less likely than not;" and the inability to render an opinion "without resorting to mere speculation." Failure to use appropriate legal language can compromise the Veteran's right to the VA's benefit of the doubt rule, which favors the Veteran (38 U.S.C.A. § 5107(b)).

In my husband's case, the VBA raters used the inconsistencies and nebulous wording of opinions to cherry-pick information from his record rather than querying the examiners for clarification. Such cherry-picking is of profound concern and calls into question the objectivity of the overall rating consideration, as well as the overarching qualifications and integrity of some of those involved in the C&P process at the Fort Harrison VA. Because VBA raters style themselves as mere processors of the information offered by VHA examiners, they assume no responsibility for misusing the information and place the entire onus on VHA examiners. Similarly, there is no assumption of responsibility on the part of VHA examiners. In her statement related to my husband's case, Dr. Cernich states: "The clinician who performs this residual evaluation does not make the benefit rating decision and the recognition that

[16] Worthen MD, Moering RG. A practical guide to conducting VA compensation and pension exams for PTSD and other mental disorders. *Psychological Injury and Law*. 2011;4:187-216.

based on review of records, cognitive disorder, NOS could be considered allows the rating official latitude to include this diagnosis as justification for benefit designation."

Why the system's raters are not medical professionals is puzzling. How is a rater without healthcare training to make sense of notes entered by VHA examiners? Simplified DBQs are not sufficient, especially since there is absolutely no standardization of reporting. Rural VA systems, where availability of qualified examiners is extremely limited, may be most vulnerable to inconsistencies between departments.

The VHA and VBA constantly point fingers at each other and the system as a whole fails to take accountability or action to rectify clear improprieties. Each department begins with a 'V' and ends with an 'A', and, frankly, as the wife of Veteran, I don't care what letter falls in between. I don't think the Veteran and his/her family should have to suffer because the two entities cannot figure out a more productive and cohesive way to work together.

VHA Directive 1603 acknowledges that "Given the importance of a thorough evaluation to the Veteran or Servicemember in terms of eligibility for future benefits, it is critical that standards are consistently enforced and applied fairly across VISNs."[17] The profound discrepancy between the language used in the VHA directives vs the actual processes in place are of particular concern. It is as if the language issued in VHA directives is used to simply pacify individuals, not define internal policy (at least in my husband's case). Moreover, the subjective language used in such directives gives the VA a way out of having to take accountability. Thus, one issue at play is the degree of authority of the directives. Are they intended as "guidelines" or are they intended as "policies"? And how are they enforced?

- ***VA plays lip service to the needs of Veterans and their families; places legal loopholes ahead of Veterans' best interests***

The VA promulgates messages to Veterans and their families to falsely bolster trust in the system. As some examples: "Integrity, Commitment, Advocacy, Respect, and Excellence" are the core values the VA self-identifies as underscoring its obligations to Veterans and their families.[18] Forming the acronym "I CARE," the VA states that "these core values come together as five promises we make as individuals and as an organization to those we serve." In addition, VHA Directive 2013-002 cites that "VHA's goal is for Veterans to describe the disability examination process as 'informative, supportive, caring, and even delightful.'"[19] Specific to the Fort Harrison VA, Christine Gregory took over as Director VA Montana Health Care System in March 2013 under the guise of being "committed to leading an organization that

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[17] Department of Veterans Affairs. Veterans Health Administration. VHA Directive 1603. "Certification of clinicians performing VA disability evalutions" [sic] April 7, 2013. Accessed 4/21/2014 at: http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1643

[18] U.S. Department of Veterans Affairs. About VA. Core Values. http://www.va.gov/about_va/mission.asp

[19] Department of Veterans Affairs. Veterans Health Administration. VHA Directive 2013-002. "Documentation of medical evidence for disability evaluation purposes." January 14, 2013. Accessed 4/22/2014 at: http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2856

embodies open communication and transparency."[20] We are here today to testify that while well-intentioned, the system, with few exceptions, is failing horribly at honoring its core values, system goals, and responsibilities.

First, those exceptions warrant recognition. Our frustrations are limited to those VA employees who do not uphold the responsibilities of their positions. There are many employees within the VA system on both VHA and VBA sides of the house who are professional and friendly and who go out of their way for Veterans. We would like to formally recognize Marcy Steffy, RN, OEF/OIF Case Manager at Fort Harrison and VISN 19 FOIA Officers Shay Perrera-Boettcher and Melissa Petersen, for their professionalism and integrity. These individuals represent the models for which the rest of the system should emulate.

For close to three years, my husband and I have been advocating for ourselves and other families in seeking proactive and effective strategies to resolve system inconsistencies at Fort Harrison. We followed the system's chain of command, voicing our concerns to multiple parties within Fort Harrison, including patient representatives; Trena Bonde, MD, Chief of Staff; Dr. Normandin, MD; Ms. Gregory; Koryn Arnold, Veterans Service Center Manager; and a gaggle of others. We also contacted the Western Regional Office (Phoenix, Arizona) to discuss the matter with Regional Director Willie Clark. Unfortunately, instead of building bridges for communication and correction, they have erected thick brick walls in efforts to silence and stonewall those with good intentions. All of our efforts to open the doors of communication to discuss our concerns and prevent them from occurring again have been and continue to be completely disregarded. It has reached ridiculous proportions; if we call the Director's office with a question, her office staff state that she will not speak with us and that any questions should be directed to the Office of Regional Counsel in Denver, Colorado (Region 16). When contacting Regional Counsel, Jeffrey Stacey, we are insulted, disrespected, called "disingenuous," and accused of being combative. Voicemails for employees, particularly Koryn Arnold, go unreturned. The administration at Fort Harrison, and by extension, the Office of Regional Counsel in Denver, and the Western Regional Office, all operate with impunity. They have tried to impose their will to silence us in order to avoid the larger implications involving accountability and their obligations to the Veteran's community.

The leadership at Fort Harrison touts that they "are committed in VA Montana Health Care System to providing the highest quality of care to our Veterans."[21] And yet when an independent state government entity identified several instances of failure to provide such care, Fort Harrison's administration tucked their heads in their shells and failed to take appropriate corrective actions. If such violations of the standard of care occurred in any other setting, that employee would immediately be put on administrative leave and/or terminated. However, to this day, Dr. Bateen continues to work at Fort Harrison as a fee-based employee conducting C&P examinations for PTSD and residuals of TBI. The fact that Dr. Bateen continues to practice is demonstrative of the fact that the Fort Harrison VA completely disregards the best interests of the Veterans.

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[20] "New director outlines goals, vision for VA Montana Health Care System" April 18, 2013. Billings Gazette. http://billingsgazette.com/news/local/new-director-outlines-goals-vision-for-va-montana-health-care/article_a7883360-bd56-505c-a4c3-86683b540dc0.html#ixzz2zXQTrit1

[21] Letter from Christine Gregory to Congressman Steve Daines (R-MT). August 22, 2013.

In order to conduct C&P examinations, all examiners must be state licensed, but can be licensed by a state other than the state in which they practice at the VA. The VA argues that because Dr. Bateen was evaluating my husband for his disability, he was not acting as a care provider and therefore is not obligated to honor the tenets of his licensing. The VA classifies Dr. Bateen as a federal employee and argues that he is immune from liability with the state, even though, he can only be an employee if he has that appropriate licensing. What is the point of requiring C&P examiners to hold licenses if they do not have to actually follow the fundamental oath they took? Where is their obligation to their professional fields and their patients and why does the VA think such obligations are not binding?

The U.S. Attorney's Office is now representing Dr. Bateen in the matter against the state (Case No. 994-2014), which speaks volumes as to the depths to which the VA will sink to avoid a change in policy that would benefit Veterans. This case is no longer about holding a licensee accountable for violating the tenets of his licensing with the state; in my opinion, the VA has now made it a case regarding state vs federal rights. It is curious that the VA uses budget concerns to justify not sending a Veteran for neuropsychological testing, yet they are more than willing to use tax-payer dollars to represent an examiner who fundamentally failed to do his job. Such actions are deplorable.

The consequences to the Veteran and his/her family of allowing VA employees to perform insufficient examinations so that C&P raters can undermine what the Veteran is rightfully due cannot be overstated. The consequences are not only monetarily based. Stresses associated with dealing with the VA adversely impact familial relationships and the situation is compounded when a Veteran has TBI with emotional components. In situations where an appropriate rating means the difference between 90% and 100%, the implications are not just financial; it is also the difference between access to vision and dental services, the difference between being potentially eligible or not for educational benefits for family members, among other benefits extended to Veterans at 100% disability.

I think the best way to convey the seriousness of this situation is to consider the perspective from other families. Can you imagine being one of those families that discovers you were short-changed, that the VA knew it and yet did nothing? Can you imagine the frustration of having to go through the appeals process and the length of time required to fix the problem, assuming it will be fixed? Can you imagine how much $100/month could improve quality of life for your family? And what about those families who may not know that they are being wronged, who may not know what questions to ask, or who may not have the time, energy, or resources to fight a bureaucratic system? Who is going to watch out for their best interests?

Recommendations and Concluding Remarks

Given what we have addressed today, my husband and I propose the following as actionable points to address shortcomings in the C&P system specific to residuals of TBI:

1. Audit the medical records and claims files of Veterans diagnosed with TBI who were seen at Fort Harrison to ensure that only the highest standards of testing are employed.

2. Initiate a VA Inspector General's investigation into whether the practices at Fort Harrison represent criminal and collusive actions to undermine Veterans' benefits.
3. Routinely retrain C&P examiners and raters on system protocols; ensure examiners use consistent language in drafting their opinions in order to obviate cherry-picking of information.
4. Amend CPEP TBI training module to meet rigorous standards of continuing education; conduct an outcomes study evaluating effectiveness of training on practice performance.
5. Expand access to CPEP TBI training module and Veterans Health Initiative on TBI to VBA raters to increase familiarity with medical terminology, etc.
6. Increase collaboration with community services to ensure appropriate access to specialized care and to obviate the need to travel long distances for basic appointments.
7. Adopt and enforce a protocol for accountability when deviations from standard practice are made.
8. Institute compassionate training to all VA employees, including administrators.

My husband and I are sickened by hypocrisies within the VA. The "I CARE" acronym and its promises are offensive to those of us who rightfully know that the system as it now stands is not capable of upholding its supposed core values. I challenge the VA to honor their promises to us of ***integrity*** *("Act with high moral principle. Adhere to the highest professional standards. Maintain the trust and confidence of all with whom I engage")* and ***excellence*** *("Strive for the highest quality and continuous improvement. Be thoughtful and decisive in leadership, accountable for my actions, willing to admit mistakes, and rigorous in correcting them")*. Until the VA actually lives up to their promises, Veterans will continue to mistrust the system.

We are exhausted fighting a system that is supposed to fight for us. My husband fought for this Country honorably. It's time for someone to fight for him and other deserving Veterans and their families.

PREPARED STATEMENT OF JERRY BOALES JR.

In 1989, I was stationed in the U.S. Army at Ft Riley, Kansas. During my time there, I was attacked by three male soldiers, grabbed and pulled in a room. I was forcibly held down by two of the males while one forcibly raped me. I was then raped by the second male. The third male did not do anything except hold me while this was going on. I was told that if I said anything I would be killed. I was in so much pain and shock that basically I was dragged to the stairs and was thrown down a flight of stairs (20 stairs) and left alone. I passed out and woke up by the cadre, I could not move so they sent me to the hospital on base. I became paralyzed emotionally, which I literally had to have a cattle prod taken pressed on my feet to bring me out of the paralyzed condition.

At this time I was so ashamed about what happened that I did not report this incident and I even told my father that I had slipped down some stairs and broke my arm. In 1990 I was discharged from the army. So for the next 16 years I kept this to myself. I was married, had three children and one night because of a nightmare, something snapped within me. The nightmares became so bad, that I could not sleep and literally I was a walking zombie for not allowing myself to sleep. Finally after six years, I started seeing a nurse practitioner—counselor at the Show low VA. I told her my story and after a year, she left and to see someone else, I would have to start all over again, which I just couldn't do. So after about a year and a half, my wife encouraged me to seek help. I was not really wanting to talk to a male doctor about my experiences, I wasn't getting any better, so I did go back to the VA , I saw a Physician (Dr. Davis), he could prescribe medications, so I continued to see Dr. Davis for almost two years. This was a one on one counseling visits. This time, I was recommended by Dr. Davis to submit for PTSD, Depression, unemployability which he documented and I can also add that in his notes he related the MST (Male Sexual Trauma). I was denied PTSD relating from the MST due to lack of evidence. However, I was service connected for depression (100%) temporary to be reevaluated after two years. I was originally denied social security disability twice which took over another two years to get that approved through the use of a lawyer. This was because I could not work and was already diagnosed as chronic depression by the Veterans Administration.

I lost my family and found myself living in a cabin as a recluse in Show low almost two years. Before the cabin, I lived in a room in my ex-wife's home which I shut myself in and went out only after people were not around. I shopped at Walmart at 2 am so I did not have to see people. I would go fishing at daybreak before anyone would be there.

In August of 2010, my son serving in the Army had been wounded in Afghanistan. I spent from August 2010 to November 2010 at Brooke Army Medical Center during his recovery. It was just me there for him. We had a lot of time to talk, but one of the last things he said to me during these conversations was, Dad, promise me that you go seek help, which I did after returning to Show low and contacted the Tucson VA. I requested to make arrangements to get into the inpatient substance abuse program. February 2011, was the quickest time that I could go there, which I did. I stayed inpatient for three months and was finally able to get into the MST inpatient group, which is a one year program. So after being inpatient for three months at the VA medical center, I then left and would live in Casa Grande. I would commute once a week to Tucson for my group sessions. I did this for nine months. The group counseling was very intense, starting with a group of eight male veterans ranging from the Korean War, Vietnam and current war. We ended with three finishing the program due to the intensity and having to relive the actual experiences.

Currently, today I see a therapist at the VA CBOC Clinic in Casa Grande averaging every two weeks since October of 2013.I have submitted three times to the Veterans Administration for PTSD relating to the MST. I have been denied three times because of lack of evidence. I did not speak up when this rape occurred. I was too ashamed. I want to acknowledge the Veterans Administration for finally recognizing that Male Sexual Trauma is and has been an ongoing problem. However being recognized is one thing, not being service connected and compensated with benefits is another. This feels that it is a slap in the face like it never happened. If it is only being recognized for treatment, then the VA is only putting a band aide on the problem. I am speaking for all male veterans who are going through these difficult experiences of male sexual trauma. I realize that MST is very difficult for anyone to talk about. But more and more, we are now seeing these experiences come out in the limelight. What is needed now? We need fair evaluation of personal stressors and physician diagnoses to service connect and give our veterans benefits what they deserve and most important need.

I would also like to comment on the Veteran Access to medical care especially in the rural area s based on my experiences. I first want to bring up that when I was in the MST program for that nine months in outpatient I had to drive 70 miles one way to attend sessions (Casa Grande to Tucson), this is 140 miles roundtrip. Even today, to continue the MST individual or group counseling I would have to still drive that distance. The program is good, the distance is not for any veteran in this situation. I might add, even in Show low, if it was to see a specialist for my knee or shoulder, I would have to travel to Phoenix, which was almost 400 miles roundtrip. Living in a rural area, I would like to see more specialists and physicians that can do immediate care, not having veterans constantly trying to get appointments. I would like to see a fully staffed VA Clinic and maintain that VA staff to assure myself and all veterans quality health care in a reasonable time frame. I also recommend a VET Center in this area that veterans can go to and seek counseling for PTSD, TBI, Sexual trauma and concerns related. It is important to me and I know it is important to every veteran living in the Casa Grande Valley.

Respectfully,

Jerry Boales Jr.

U.S. HOUSE OF REPRESENTATIVES

Committee On Veterans' Affairs . One Hundred And Thirteenth Congress
House Subcommittee On Veteran Affairs . Subcommittee On Oversight And Investigations

OVERSIGHT FIELD HEARING

"Access To Mental Health Care And Traumatic Brain Injury Services"
Addressing The Challenges And Barriers For Veterans

Thursday . April 24th. 2014 . 1:00 Pm

R.E. Lindsey Jr. Auditorium
Southern Arizona VA Health Care System
3601 South Sixth Avenue . Building 4 . Room 109
Tucson, Arizona 85723

TESTIMONY OF JOHN D. DAVISON

Honorable Chairman Mike Coffman and Distinguished House Members;

It is a privilege to testify today and I respectfully Thank You for the invitation to do so. I sincerely appreciate the opportunity to address the Subcommittee regarding the hardships of Veterans and the difficulties which confront them regarding their treatment and care in VA systems.

The past several weeks have been very difficult for our Family following the passing of our beloved Son Lance C. Davison on February 9th, 2014. The hardest things I have ever done in my life were having to tell his Mother, Sister and Brother, writing an Obituary for him and laying him to rest, but from the beginning we have all been committed to our Duty in Honoring and Respecting this incredible Man.

Good memories of a simpler time have often occupied our thoughts in thinking of Lance.

Friday, March 27th, 1998 was a day of joy and proud reflections as we joined our son during his graduation at "Marine Corps Recruit Depot" in San Diego, California. The ceremony, moved into an auditorium because of rain, was so inspiring for parents and families as we all witnessed the transformation that had taken place in our young men... now Marines.

The early morning ocean layer had dissipated by the time we could go outside and finally see our son. So very proud we were of him, we met his DI's, Company Officers, his fellow Marines and their families. The sun was shining and it was an exciting, cheerful and fulfilling time together - much sadder and more difficult times were ahead.

Lance excelled in the U.S Marine Corps and cherished being a Marine. He was completely dedicated to the regimes of the infantry becoming an accomplished marksman and scout sniper.

In November 2000 he completed "USMC Amphibious Reconnaissance School" on Coronado Island (Naval Expeditionary Warfare Training Group) and cleared screening for assignment with the 1st Force Reconnaissance Company at Camp Las Flores (Camp Pendleton).

With Force Recon he earned his "jump wings" and "scuba bubble" and engaged in extensive, specialized and elite training worldwide. The June 2001 edition of "Leatherneck" (Magazine of the Marines) presented Lance on the front cover, with the feature article; "Recon-Independent Operators: Exceptional Men, Exceptional Training".

As for many - Tuesday, September 11th, 2001 changed our world. The tragedies in New York, Washington DC and Pennsylvania are forever etched within us but for families with men and women in the military it meant one thing. These cowardly acts of terror had far reaching ramifications worldwide, effecting all Americans and reaching into our very households... changing our lives forever.

Lance had seen war before during operations on the island of East Timor, but it would be much different now.

Lance was an elite MARSOC Operative. Immediately following 9-11, he was sent on missions in Afghanistan in support of "Operation Noble Eagle", "Operation Enduring Freedom" and any such operations associated with the World Trade Center and Pentagon attacks.

As the "War on Terror" escalated, Lance was assigned to the 3rd Battalion 23rd Marines 1st Marine Division during "Operation Iraqi Freedom" where he was awarded a Bronze Star and a Navy Commendation Medal for separate combat actions, valor and bravery in 2003.

He returned to Iraq again in 2005 (Presidential Orders) and 2006. I recently learned that he was a lone survivor of an IED explosion which killed four other Recon Marines. He engaged in close quarter combat, endured numerous injuries from gunshot wounds, shrapnel, RPG attacks and suffered post-traumatic stress and traumatic brain injuries.

SGT. Lance C. Davison was an "American Hero", he had a top secret clearance and through his leadership and courage he saved many young Marines during OEF/OIF combat operations and assisted civilian casualties under fire without concern for his own safety and well-being.

Lance's integrity, honor, fortitude, self-will, determination, motivation to overcome all adversity and obstacles, and his character is unquestionable.

Through all these experiences Lance maintained "presence of mind". He told me once that one's greatest weapon is "calm" when encountering any difficult situation and "observe don't admire" - keep all things focused and in perspective.

Lance was "Honorably Discharged" from the U.S. Marine Corps in 2006 and continued his vigilance during civilian life. He graduated from the Arizona Law Enforcement Academy, third in his class, with a 97.7% score for physical condition. As a Flagstaff Police Officer he received two "Commendations for Valor" Citations, where in one instance he again was faced with losing his life.

He always kept himself in top shape, playing football and running in ultra-marathons while always eating and living healthy.

He served his community and was active in "MCL Toy's For Tot's", assisting wounded warriors and supported the "Wounded Warrior" and "Lone Survivor Foundations".

As a "Chief Sniper Instructor" he certified high-level military personnel and SOCOM Operatives, training law enforcement officers at local, county, state and federal levels at the GPS Sniper School in Phoenix, Arizona.

Lance was working on a Bachelor's Degree in Business, had an AA Degree in Criminal Technology and earned an Administration of Justice transfer Degree.

Lance conceived "Raven 2 O.D.G." (Operator Development Group) a long range tactical marksmanship school and was the Owner/Operator of this disabled veteran owned business. It was his passion and he was greatly respected and came highly recommended within the special op community.

While accomplishing all this and even more Lance continued suffering from the "invisible wounds" caused by combat related "Post Traumatic Stress" (PTSD) and "Traumatic Brain Injury" (TBI).

He also had significant visual perceptual deficits, difficulty with comprehension and needed cognitive-linguistic therapy.

During the early morning of Sunday, February 9th, 2014 near sunrise, Lance succumbed to his combat wounds received during two wars in the Middle East and took his life.

We had Lance with us for ten years after Iraq 2004, for which we are very thankful.

It was a blessing for us, one that many parents and families did not have. Eric Lindstrom, a close friend and a fellow Flagstaff Police Officer with Lance was previously killed in action while in Afghanistan.

HELPING VETERANS WITH PTSD AND TBI

When we are talking about our men and women of the military who like Lance, have given all they have for their country, protecting all that they love, we are treading on sacred and hallowed ground.

We must carefully approach this subject, always honoring them and respecting their sacrifices, their infirmities and their privacy.

Lance endured significant agony and suffered greatly from the uncertainties and harsh realities of post-traumatic stress and traumatic brain injuries. He sought help from the U.S. Military, the Veterans Administration and several professional sources.

I have been involved for many years in Veterans' issues within our community. Since Lance's passing, I have been even more determined to piece it all together, I have connected some of the dots, but there are many unanswered questions.

Much of the information necessary to better understand what really happened to Lance (during the course of his medical and clinical care) is compiled within the records of the Department of Defense (DoD) and the Veterans Administration (VA).

It is not my intent or desire to blame or accuse these organizations or anyone without full knowledge and a complete understanding of how Lance's situation was handled.

It is very important to our family that we all work together to:

- Determine facts and advance truth
- Encourage DoD policies to provide updated, enhanced and mandatory PTSD/TBI training for all military personnel and their families before and after deployments
- Resolve to improve overall healthcare conditions for all Veterans within the VA system
- Resolve to fully investigate, review, evaluate and update the VA approach to treatment of Veterans with PTSD, TBI and mental health concerns
- Encourage VA and Community Initiatives to provide updated, enhanced educational opportunities for the families of Veterans diagnosed with PTSD and or TBI
- Engage national "Veteran Service Organizations" (VSO) in a comprehensive partnership with the DoD and VA to change the status quo relating to PTSD and TBI tragedies

- Resolve to fully fund (public/private) and implement advanced scientific, technological, medical and clinical research for the treatment of PTSD and TBI

We must as a Nation move to solve the critical issues associated with PTSD/TBI and prevent the tragedy of increased suicides of military personnel and veterans.

EVERY DAY THERE ARE OVER TWENTY SUICIDES BY US MILITARY VETERANS

PTSD and TBI has become the "signature" medical concern for OEF and OIF Veterans.

We cannot shamefully be apathetic or ignore the cries for help (or the silence) by those who should be most esteemed.

While, I do not have the all the answers, the current situation is a national tragedy... it is an epidemic of huge proportions with tragic ramifications for our Military and Nation.

I do however know my son... his accomplishments, his achievements and successes, his challenges, his hardships, his mistakes, his set-backs, his improvements, his legacy...

The story of Lance Davison and his struggle with combat inflicted post-traumatic stress and traumatic brain injuries is well documented. Many newspaper articles (in Flagstaff) have been written about him and they carry a message of concern, despair and hope.

As we look back over the years and reflect... PTSD and TBI was a critical health problem for Lance, his family and friends... We all shared his suffering... Solutions, Answers and Understanding did not come easy for any one of us.

Lance Davison, in essence, has become the face of PTSD and TBI for all of us.

As his Father, I respect my Son now even more for what he did for all of us during his amazing life. I was not his best friend or his buddy... I was his Dad and taught him self-reliance and responsibility; he took it and became the most courageous man I know.

I would like to close with these recommendations and observations:

- We cannot do enough for the U.S. Military and the American Veteran
- Our Leaders and Government Officials have a moral obligation to fulfill the promises made to every Veteran
- The Veterans Administration must be fully funded to provide exceptional health care and services
- VA Hospitals and Clinic's must be professionally managed, adequately and professionally staffed with experienced medical personnel

- Many Veterans, who reside in rural and remote areas cannot easily access VA facilities they must be provided with increased services especially in impoverished regions, native communities and tribal lands, special attention needs to be given to this so Veterans have equal access and same services as metropolitan areas
- Following discharge from the military, as any Veteran will tell you, transition back into civilian life is extremely difficult, this is compounded greatly if they have PTSD/TBI
- The situation has improved somewhat in the military, but standing on the streets in a war zone one day and then back in hometown America soon after; is inherently dangerous... they need more time to decompress, perhaps even up to a year
- DoD and the U.S. Military must develop essential criteria and improve the documentation and recording of combat conditions and what was and is occurring during operations, Veterans are returning and are expected to somehow prove to the VA they were wounded or injured during their time in service, the current status quo leaves it wide open for fraud and deserving Veterans do not receive the care and service they require
- Combat Veterans generally avoid talking about their experiences with family, they have no desire to share these memories or the horrors they have seen with those whom they love
- Combat Veterans relate with each other, it is very difficult, counter-productive and even insulting to them when "analyzed" by staff psychologists at the VA who do not have these experiences, this was a huge concern with Lance (and most Veterans diagnosed with PTSD/TBI) during critical evaluations and therapy sessions
- PSTD/TBI patients often have no reliable safety net, with no consistent health care provider (constant personnel transfers etc.)
- The VA tool box for assisting PTSD/TBI victims seems very limited, there is an inappropriate and troubling over-reliance on the administering of drugs for treatment, many have psychotropic properties, at times Lance was on several prescribed "cocktails" (containing sleep aids, anti-depressants etc. - which he found he was sensitive to) by the time he was "pulled off them" he was on 32 different cocktails, 32 different combinations of drugs... causing many problems for Lance
- We never received a call from VA regarding Lance's condition or treatments
- I believe that there is also a disconnect in treatment of PTSD and TBI, to much emphasize is placed on the psychological aspects and mental health, when in reality it is the physiological aspects that need to be focused on, actual wounds to the brain (affecting the mind) subsequently causing our Veterans so many problems, extreme physical trauma has occurred and we need to realize and understand this relationship

During the oral portion of the hearing I will read a statement by Lance addressing his condition... it will sum up what has occurred to him in a shocking manner...

The Best Way We Can Honor Lance And The Many In The U.S. Military And Our Veterans
Who Struggle Everyday With PTSD & TBI Is By Resolving That They Receive
The Finest Healthcare Possible With A Guarantee To Those Who Are Suffering
Be Encouraged And Have Hope You Are Not Forgotten And We Will Not Rest Until
Your Plight Is Improved And Your Condition Mitigated.

Thank You So Very Much For Your Time And Consideration...

Please Respond To These Admonishments & Act Decisively!

Sincerely,

John Davison
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Email: john.davison54@yahoo.com

PREPARED STATEMENT OF BRAD HAZELL

Thank you for this opportunity to testify to the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations regarding "Access to Mental Health Care and Traumatic Brain Injury Services: Addressing the Challenges and Barriers for Veterans". My name is Brad Hazell I served in the United States Marine Corps from November of 1999 to June 2005. During this time period I served two tours in Iraq. The first tour took place during the invasion in 2003 where I was a Scout for the 1st Light Armored Reconnaissance Battalion. My second tour took place in 2004–2005 where I was an Infantry Squad Leader for 2nd Battalion 24th Marines. During the second tour my squad was hit by several IEDs, one of which killed one of my marines and wounded three (myself included).

Upon returning to the states I resumed my life and returned to my civilian job. I had already started to struggle with PTSD Symptoms. Within a year of being home I had gotten to the point where I was self-medicating with alcohol daily. Eventually I came to the conclusion that I could no longer deal with these issues myself and one night I called the Veterans' Crisis Line. The following day I went to the closest VA Clinic with was located in Alexandria Virginia. I was extremely fortunate, due to my desperation, a counselor at the clinic saw me that day even though I had not yet been enrolled in the VA Healthcare System.

I began weekly sessions with a counselor and had monthly appointments with a psychiatrist. Eventually I agreed to be treated at an inpatient facility located in Martinsburg West Virginia. First I was treated for alcohol abuse, then for PTSD. Unfortunately due to the intense emotions that accompanied the PTSD program I withdrew myself from the program to return to work. Within a year I decided to return to my home state, Arizona. I was given a three month supply of medications with instructions to enroll in the VA Healthcare System in Arizona so that I could continue my treatment for PTSD.

Upon arriving in Arizona I immediately began looking for work. I had two jobs, both of which last less than two months. I ran out of my medication and attempted to manage my PTSD on my own. After being without medications for over a month, I became emotionally distraught and finally enrolled in the Phoenix VA Healthcare System. When I attempted to make an appointment to be seen by a psychiatrist, so I could resume my medication, I was informed that I had to wait at least a month if not longer. I pleaded with the hospital to see if they could at least refill my prescriptions that I had been when I lived in the D.C. area. The Phoenix VA Hospital's solution was to treat me inpatient at their mental health ward. This only made matters worse. Within three days I demanded to be released and signed myself out of the hospital. The doctor refused to put me on the same medication stating the some of the medications were not on their formula.

After leaving the mental health ward in Phoenix I moved in with my mother in Casa Grande. Living in Casa Grande, I was now in the jurisdiction of the Southern Arizona VA Healthcare System (SAVHCS). My experience was much better with SAVHCS. I was seen within two weeks by a psychiatrist at the Tucson VA Hospital and started therapy with a counselor at the Casa Grande CBOC. SAVHCS fell under yet another formula and they were able to put me on similar medications that I was on while living in the D.C. area. Over several years my medication was decreased and I vastly improved.

Unfortunately PTSD hits in waves. I missed an anniversary date from an incident in Iraq during which several marines from my unit were killed. This sent me into a severe depressive episode. I canceled my appointments with my counselor and my psychiatrist. After several months of this depressive episode I eventually tried to take my own life by overdosing on a three month supply of sleeping pills. I awoke several days later in an intensive care unit and was then transferred to the Tucson VA Hospitals Mental Health Ward where I stayed for several weeks.

Prior to discharge a safety plan was implemented and I was place on a "High Risk" list with the VA healthcare system. That being said when I called to make my first counseling appointment when I left the hospital the day after my discharge; I was told that it would be several weeks until I could be seen. When I informed the receptionist about my recent hospitalization, she saw the flag in the system and I was setup with an appointment within a couple of days. I remained on the high risk list for several months until my mental healthcare providers deemed that it was safe to take me off.

Since that time I began working as a veterans' advocate helping veterans navigate the Veterans Benefits Administration. To this day I am still treated by the Southern Arizona VA Healthcare System.

Respectfully, Brad Hazell

PREPARED STATEMENT OF DR. LISA K. KEARNEY

Chairman Coffman, Ranking Member Kirkpatrick, and members of the Committee, thank you for the opportunity to appear before you today to discuss access to treatment for Veterans who have suffered from a Traumatic Brain Injury (TBI) or Posttraumatic Stress Disorder (PTSD) once they returned home. I am joined today by Dr. Joel Scholten, National Director of Special Projects, Physical Medicine and Rehabilitation Service, VHA, Mr. Jonathan H. Gardner, Medical Center, Director Southern Arizona VA Health Care System (SAVAHCS), Mr. Joshua Redlin, Team Leader, Tucson Vet Center, and Mr. Rod Sepulveda, Rural Health Program Manager Northern Arizona VA Health Care System.

VHA TBI Program

VHA provides state-of-the-art comprehensive health care and support services for Veterans with both combat and civilian-related TBI, leveraging its nationwide resources through the Polytrauma System of Care (PSC). Through this program, the Department continues to advance the evaluation, treatment, and understanding of TBI in a variety of ways by developing and implementing best clinical practices for TBI; collaborating with strategic partners including Veterans Service Organizations, community rehabilitation providers, and academic affiliates; providing education and training in TBI-related care and rehabilitation; and conducting research and translating findings into improved clinical care. In fiscal year (FY) 2013, VA invested $231 million in TBI care for Veterans. Of this amount, $49 million was for care of Veterans of Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn (OEF/OIF/OND).

All OEF/OIF/OND Veterans who receive health care within VA are screened for possible TBI, and from April 13, 2007, through December 31, 2013, over 804,000 OEF/OIF/OND Veterans have been screened. More than 151,000 of these Veterans screened positive for possible TBI and were referred for comprehensive TBI evaluations by specialty teams; over 65,000 of these screened Veterans were diagnosed with sustained mild TBI (mTBI) and received appropriate follow-on care. Veterans, who were initially screened positive but were later determined not to have TBI, were referred for medical follow up as appropriate for their condition. Veterans with moderate to severe TBI receive initial diagnosis and treatment on inpatient hospital wards. Patients who were diagnosed as having sustained a TBI and continued to experience chronic problems requiring rehabilitation and treatment received an Individualized Rehabilitation and Community Reintegration Plan of Care to help coordinate services across episodes and sites of care. In this way, problems that may be related to TBI and polytrauma are addressed early on and proactively so they can be managed effectively before they become chronic disabilities.

The PSC has a four-tier design that ensures access to the appropriate level of rehabilitation services based on the needs of the Veterans recovering from TBI and multiple, co-occurring injuries (i.e., polytrauma). This system of care includes:

- 5 regional Polytrauma Rehabilitation Centers, that serve as regional referral centers for acute medical and rehabilitation care and as hubs for research and education;
- 23 Polytrauma Network Sites (PNS), that coordinate polytrauma services within the Veterans Integrated Service Networks;
- 87 Polytrauma Support Clinic Teams who provide specialized evaluation, treatment, and community reintegration services within their catchment areas; and
- 39 Polytrauma Points of Contact who deliver a more limited range of rehabilitation services and facilitate referrals to the other PSC programs, as necessary.

The tiered model of the PSC helps ensure that Veterans with TBI and polytrauma transition seamlessly between the Department of Defense (DoD) and VHA, and back to their home communities through the provision of evidenced-based rehabilitation services and care coordination.

VHA PTSD Treatment

VA is one of the largest integrated health care systems in the United States that provides specialized mental health treatment for PTSD. In FY 2013, over 530,000 Veterans (including over 140,000 OEF/OIF/OND) received treatment for PTSD in VA medical centers and clinics, up from just over 500,000 Veterans (including over 100,000 OEF/OIF/OND) in FY 2011. VA provides care for PTSD in a variety of settings including inpatient, residential, as well as specialty PTSD outpatient programs and general outpatient care.

VA provides state-of-the-art care for Veterans with PTSD delivered by more than 5,200 VA mental health providers who have received training in Prolonged Expo-

sure and/or Cognitive Processing Therapy, the most effective known therapies for PTSD. Medication treatments also are offered and may be especially helpful for specific symptoms of PTSD.

VA operates a National Center for PTSD (NCPTSD) that provides research, consultation, and education to clinicians, Veterans, family members and researchers. The national PTSD Mentoring Program, which works with every specialty PTSD program across the country is designed to promote evidence-based practice within VA. NCPTSD's award winning PTSD Web site (www.ptsd.va.gov) provides research-based educational materials for Veterans and families, as well as for the providers who care for them. To help Veterans access needed care, AboutFace, which can be found at *http://www.ptsd.va.gov/apps/AboutFace/* was added in 2012, is an online video gallery dedicated to Veterans talking about how PTSD treatment turned their lives around. Each June, NCPTSD runs a national campaign to raise awareness about PTSD and its effective treatment during PTSD awareness month. NCPTSD's Consultation Program was established in 2011 to reach any VA provider who treats Veterans with PTSD, including those in VA PTSD specialty care, those in other areas of mental health, primary care providers, and case managers. The Consultation Program helps with questions about assessment and treatment services for Veterans with PTSD. By the end of FY 2013, there were over 650 consultations completed, over 550 for PTSD and over 75 for Suicide Risk Management, a feature added this year to the Consultation Program.

Interdisciplinary Pain Management

There has been an ongoing and broadening collaborative approach within the National Pain Management Program Office, Rehabilitation and Prosthetic Services (RPS), Primary Care Services, Mental Health Services, Specialty Care Services and Nursing Services to educate the field on the stepped-care model for pain management. On December 15, 2010, the Under Secretary for Health chartered the Interdisciplinary Pain Management Workgroup to assist Veterans Integrated Service Network (VISN) Directors in establishing which specialty pain services will be available to all Veterans and how best to determine the need for tertiary pain care and pain rehabilitation services. The Pain Medicine Specialty Team Workgroup, chartered on January 26, 2012, is providing support to Patient Aligned Care Teams (PACT)/primary care and pain specialty care services through collaborative care models and participation in provider and team education through telehealth, e-consults, and Specialty Care Access Network-Extension for Community Healthcare Outcomes (SCAN–ECHO). VA SCAN–ECHO experts provide didactics and case-based learning to PACT members using videoconferencing technologies to strengthen the competencies of providers in pain management.

As of January 2014, VA has ten sites in seven VISNs with Commission on Accreditation of Rehabilitation Facilities-accredited pain programs. RPS has collaborated with the Employee Education System to provide a wide variety of TBI and pain-related training offerings to all VA clinicians at their desktop via VA's Talent Management System, including handouts, management algorithms, video lectures and workshops, and training courses. Other ongoing training venues available to primary care clinicians and nurses include:

- Conference calls and training
- Post-Deployment Integrated Care Initiative (PDICI) Community of Practice (CoP)
- Pain PACT CoP (monthly)
- PSC/TBI System of Care
- Primary Care Mental Health Integration
- Health Services Research and Development (HSR&D) "Spotlight on Pain Management" calls
- List serve Web sites (Physical Medicine and Rehabilitation Program Office Web site, Pain Management Program Office, PDICI Wiki on post-deployment care)
- SharePoint sites (Primary Care Staff Educational Resources SharePoint for PACT, OEF/OIF/OND National SharePoint)
- Training applications for clinicians on smart phones and tablets (TBI APP available 4th Quarter of 2013 and T2 mTBI Pocket Guide)

SAVAHCS Mental Health Services

SAVAHCS, in Tucson, Arizona, provides comprehensive mental health services to Veterans in the Tucson metropolitan areas and Southern Arizona. These services include Inpatient Psychiatry, the Evaluation and Brief Treatment of PTSD Unit (EBTPU), Inpatient Geropsychiatry, Primary Care-Mental Health Integration (PC–MHI), Opioid Replacement Treatment, Substance Use Disorder Treatment Programs

(SUD–TP), Substance Abuse Residential Treatment Program (SARRTP), General Outpatient Mental Health, Outpatient Primary Care for Seriously Mentally Ill (SMI) Veterans, Homeless programs, Mental Health Intensive Case Management (MHICM), and Psychosocial Rehabilitation and Recovery Center (PRRC).

SAVAHCS monitors access to mental health clinics and programs to enhance access for our Veterans. Access to mental health services is managed through PC–MHI. This program supports Primary Care PACT by providing a Mental Health psychiatrist and a team of social workers who are co-located in Primary Care Clinics. This team provides same day management of Veterans' mental health concerns thus reducing time and location barriers to access to care. In FY 2013, the SAVAHCS PC–MHI served 5,168 unique patients. This included 15,699 PC–MHI clinical encounters and 2,752 new PC–MHI patients. In FY 2013, PC–MHI exceeded all Mental Health Screening performance measures related to alcohol use, post-traumatic stress disorder, and depression. In FY 2013, the Mental Health Clinic at SAVAHCS provided 28,003 encounters and treated 7,233 unique patients.

SAVAHCS has established strong relationships with the community. On August 14, 2013, SAVAHCS hosted a Mental Health Summit which focused on coordination of care for homeless Veterans, and access to mental health services for Veterans and their families. Over 90 community participants attended this summit and provided valuable information about resources available to Veterans in the community. SAVAHCS will be hosting another Mental Health Summit in August 2014 with a focus on mental health access. In addition, SAVAHCS will be hosting a Homeless Summit in May 2014 which will bring together community partners and SAVAHCS staff who work with the homeless. This summit will provide an avenue for developing further outreach activities. SAVAHCS is also participating in the "25 Cities Initiative" which is a collaborative effort between local community leaders, SAVAHCS, VHA's Homeless Program Office, and our Federal partners, the Department of Housing and Urban Development and U.S. Interagency Council on Homelessness. The goal of this initiative is to identify and prioritize community resources and assist communities in removing barriers.

Our Supportive Education for Returning Veterans (SERV) program provides credit-bearing courses for student Veterans utilizing their GI Bill benefits to increase retention and successful graduation rates at the University of Arizona. SAVAHCS' SERV program is a best practice, and this model has been adopted at colleges and universities throughout the country, including the Universities of South Dakota, New Mexico, and Mississippi State University. SAVAHCS staff are currently consulting with the Universities of Montana, South Carolina, Rhode Island, Rutgers University, and Massachusetts Institute of Technology to help with the development of SERV programs at these institutions.

The EBTPU is a unique program in VA. It provides evidence-based treatment to cohorts of six Veterans struggling with combat-related PTSD. The program is administered over 4 weeks in an inpatient setting and accepts referrals from all over the country. Outcomes data have demonstrated sustained reductions in PTSD symptoms and high levels of Veteran satisfaction.

SAVAHCS' Polytrauma Network Site (PNS)

SAVAHCS serves as the PNS in VISN 18 and coordinates key components of post-acute rehabilitation care for individuals with polytrauma and TBI across the VISN. Since 2010, VISN 18 has experienced a 47 percent growth in the number of Veterans treated in polytrauma clinics. The VISN has improved access to interdisciplinary teams of rehabilitation specialists, case management, and psychosocial support services. Rehabilitation services for TBI include screening, comprehensive evaluations, and interdisciplinary treatments that promote independence and community re-integration including various therapies, counseling, vocational rehabilitation, and prescription of prosthetic and adaptive devices.

TBI frequently occurs in polytrauma patients combined with other disabling conditions, including depression, PTSD, and other mental health conditions. The hallmark of rehabilitation care provided at the PNS is the collaboration of specialists from different disciplines in the evaluation and treatment of symptoms related to TBI and polytrauma. Mental health professionals are key members of the interdisciplinary polytrauma teams (IDT) participating in the individualized assessment, planning, and implementation of the plan of care for Veterans served at the PNS.

In order to expand the availability of specialty TBI services across VISN 18, we focused on provider education and on the use of telehealth technologies. The SAVAHCS PNS program has established mini-residencies targeting provider education and training on TBI evaluation, treatment, and care coordination. Clinicians completing this training are mentored via additional telehealth observation until competencies in TBI evaluation and management are demonstrated. We also lever-

aged the increased availability of telehealth technologies to allow specialists from VA's larger medical centers to reach out and provide medical services and consultation to Community- Based Outpatient Clinics (CBOC) located in rural and highly rural areas. Since 2010, we have seen a 70 percent increase in TBI and polytrauma visits completed via telehealth. The number of telehealth consultations with Veterans residing in rural and highly-rural areas has also increased steadily to make up as much as 37 percent of the overall telerehabilitation workload in FY 2013.

In addition to the leadership role in coordinating TBI rehabilitation services across VISN 18, the SAVAHCS PNS has implemented innovative programs that facilitate community re-integration of Veterans with TBI and polytrauma. Noteworthy among these are the series of group activities that provide injured Veterans with opportunities to learn new skills and to apply them in community-based environments. These programs have the added benefit of engaging Veterans' families and services outside VA to support Veterans in their community re-integration efforts.

Through SAVAHCS PNS outreach efforts, other VA programs and community partners have been brought together to develop multidimensional programs that address the complex needs of Veterans with TBI and polytrauma. Among the results of these efforts are the Adaptive Sports Programs, the VISN 18 program for managing Veterans with complex pain, a vision therapy clinic, and the headache management clinic. The SAVAHCS PNS also engages with the Arizona Governor's Council on Spinal and Head Injuries to link education, rehabilitation, and employment resources together to serve the vocational rehabilitation goals of injured Veterans. Other partners in this effort include VA Vocational Rehabilitation, the Arizona Coalition for Military Families, the University of Arizona, Pima Community College, and the Arizona Department of Economic Security, Rehabilitation Services Administration.

SAVAHCS' Relationship With Native American Community

Native Americans serve in our Nation's military at the highest rate per capita of all ethnic groups. We, at SAVAHCS, honor their service through our programs and services for Native American Veterans, our relationships with Indian Health Service *https://eop.skillport.com/skillportfe/login.action* (IHS) and other Native American community organizations, and cultural awareness training of our staff. In collaboration with IHS, SAVAHCS also honors and celebrates their service and sacrifices with an annual Gathering of American Indian Veterans event, which draws attendees from around the State of Arizona, to help American Indian Veterans learn more about the benefits they have earned.

SAVAHCS respects the unique needs of our Native American Veterans by having a dedicated Native American Veteran Program. SAVAHCS is a place of healing for our Veterans, and through our Native American Veteran Program, we have learned invaluable lessons from Native Americans about the holistic healing process which we have incorporated into our programs. For example, SAVAHCS has a 24-day, inpatient EBTPU which helps Veterans who come from across the country. At graduation, the Veterans are blessed with a Native American cleansing ceremony. We also host weekly Native American Talking Circles.

Our relationship with IHS provides a vital connection to the five local Native American tribes. To better identify the needs of our Native American Veterans, SAVAHCS has trained 250 IHS Benefits Coordinators concerning eligibility for VA health care services.

Additionally, we have completed five (5) VA and IHS local implementation plans under the December 5, 2012, National Reimbursement Agreement between VA and IHS, under which VA reimburses IHS for direct care services provided to eligible American Indian/Alaska Native Veterans in IHS facilities. Under the National Reimbursement Agreement, approximately 700 SAVAHCS Native American Veterans are eligible to receive VA reimbursement to IHS for services provided by IHS.

SAVAHCS is committed to our Native American Veterans and continues to build partnerships with organizations that can bring additional services to all Veterans. Our Rural Health Coordinators and Community Referral Center Case Managers routinely meet with our IHS partners to ensure that all health care needs are meet for the eligible Veterans. We want to be present in our community and actively engage in building a more Veteran-centric community. Since October 1, 2013, SAVAHCS Eligibility and Enrollment outreach staff have conducted 57 outreach events, connecting with over 4,800 Veterans and their family members; several of these events were specifically targeted to Native American Veterans.

Readjustment Counseling Service

VA's Vet Centers present a unique service environment—a personally engaging setting that goes beyond the medical model—in which eligible, Veterans,

Servicemembers, and their families can receive professional and confidential care in a convenient and safe community location. Vet Centers are community-based counseling centers, within Readjustment Counseling Service (RCS), that provide a wide range of social and psychological services including professional readjustment counseling to eligible Veterans, Servicemembers, and their families; military sexual trauma (MST) counseling for Veterans; and bereavement counseling for eligible family members who have experienced an active duty death. The Tucson Vet Center, like those throughout the country, also provides community outreach, education, and coordination of services with community agencies that link Veterans and Servicemembers with other needed VA and non-VA services. A core value of the Vet Center is to promote access to care by helping those who served and their families overcome barriers that may impede them from using those services. For example, all Vet Centers have scheduled evening and/or weekend hours to help accommodate the schedules of those seeking services.

The Vet Center program was the first program in VA, or anywhere, to systematically address the psychological traumas of war in combat Veterans. The program was established a full year before the definition of PTSD was published in the Third Edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM III) in 1980.

There are currently 300 Vet Centers located throughout the United States, Puerto Rico, Guam, and American Samoa. Vet Center staff provide a wide range of Veteran-centric psychotherapeutic and social services to eligible Veterans and their families in the effort to help these individuals make a successful transition to life after service in a combat zone or area of hostility. VA has a fleet of 70 Mobile Vet Centers that provide outreach and services to Veterans and families in areas geographically distant from existing VA services. These vehicles also are used to provide early access to Vet Center Services to Veterans newly returning from war via outreach to demobilization active military bases, National Guard, and Reserve locations nationally.

These services include:

- Individual and group counseling for eligible individuals and their families;
- Family counseling for military-related readjustment issues;
- Bereavement counseling for families who experience an active duty death;
- MST counseling and referral, if required;
- Educational classes on PTSD, Couples Communication, Anger and Stress Management, Sleep Improvement, and Transition Skills for Civilian Life;
- Substance abuse assessment and referral;
- Employment assessment and referral;
- Screening and referral for medical issues, including mTBI, depression, etc.; and
- Referrals for Veterans Benefit Administration benefits.

Like Vet Centers throughout the country, the Tucson Vet Center is a small team of six staff members reminiscent of a military squad. The Tucson Vet Center is staffed by a team leader, three readjustment counselors, an office manager, and an outreach specialist. The staff also includes a qualified MST Counselor and a Family Counselor.

The Vet Center's ability to rapidly and effectively respond to acute PTSD and other post-war readjustment difficulties makes it an integral asset within VA. As the community's first point of contact with many Veterans returning from combat, Vet Centers also serve as the front door for referring many individuals for other needed VA services. Vet Centers also promote collaborative partnerships with VA health care and mental health professionals to better serve Veterans requiring more complex care. In addition to maintaining a bi-directional referral process with local VHA facilities, Tucson Vet Center staff also participate in weekly care coordination meetings with VA medical center mental health clinicians to ensure that all shared Veteran clients are receiving the best possible care from VA.

For individuals who are distant from the Tucson Vet Center, staff are bringing readjustment counseling to them through the creation of community access points in the communities in which they live. At these locations, counselors can provide services on a regularly-scheduled basis that are in line with the needs of that community. For example, the Tucson Vet Center maintains a community access point in Sierra Vista, Arizona and provides readjustment counseling twice a week to eligible local Veterans and Servicemembers stationed at Fort Huachuca.

The Vet Center Program remains unique in the eyes of those who have served thanks to the ability of Vet Center Staff to personally engage the individual Veteran or Servicemember in a safe and confidential environment that minimizes bureaucratic formalities. Confidentiality with our Veterans and their families is of para-

mount importance. Vet Center staff respect the privacy of all Veterans and Servicemembers and hold in strictest confidence all information disclosed in the counseling process. No information will be communicated to any person or agency outside of RCS unless authorized by law.

Conclusion

VHA provides comprehensive health care and support services for Veterans with both combat and civilian-related TBI through its nationwide Polytrauma System of Care. VHA also provides care for Veterans with PTSD through a variety of settings including inpatient, residential, specialty PTSD outpatient programs and general outpatient care. Care for PTSD is delivered by more than 5,200 VA mental health providers who have received training in Prolonged Exposure and/or Cognitive Processing Therapy, the most effective known therapies for PTSD. These TBI and PTSD programs enable timely access to treatment as part of the VA's efforts to deliver the high quality health care and support our Veterans have earned.

Mr. Chairman, this concludes my testimony. Thank you for the opportunity to appear before you today. At this time, my colleagues and I would be pleased to respond to questions you or the other Members of the Subcommittee may have.

FOR THE RECORD

STATEMENT OF TANA OSTROWSKI

Thank you for this opportunity to submit a written testimony on this most important topic. My name is Tana Ostrowski. For disclosure purposes, I am currently serving in my third term as Chair of the Governor's Traumatic Brain Injury Advisory Council for the state of Montana. I am also a direct care provider with a post acute brain injury rehabilitation program located in Missoula Montana. I am submitting this written testimony as a concerned citizen and not specifically representing either of the previously mentioned groups.

As members of the committee are aware, combat related traumatic brain injury disabilities have increased among our Veterans. Traumatic brain injury has been recognized as a major public health issue for as long as I have worked in the field and I am now entering my 27th year providing rehabilitative services to survivors of TBI. Montana has a statistically high number of Veterans. The majority of our state is classified as rural and/or frontier. This is relevant as it emphasizes the barriers that citizens of Montana encounter when trying to access TBI related therapies, Veterans as well as civilian.

I am writing today to support efforts that facilitate Veterans, their family members and care providers' access to skilled civilian providers within their geographic locations. There is significant evidence that indicates rehabilitation outcomes are improved when individuals are closer to their homes and support systems. In terms of resources, it is more cost effective to have a Montana Veteran receive TBI rehabilitation within the state of Montana vs. sending them to Colorado or other out of state facility. What is even more important is that TBI affects each individual differently. Service providers who specialize in TBI rehabilitation understand the unique needs of the person served. Cognitive changes, whether they are related to basic functions such as attention, memory or information processing, or executive skills like self monitoring/self regulation, organization, mental flexibility etc. all impact an individual's day to day function. The rehabilitation process does not end in the clinic. Allowing Veterans to access skilled civilian providers will allow for improved rehabilitation outcomes, significantly improved continuum of care and follow up, reduce stress and is certainly more cost effective.

It is truly a disservice to our returning Veterans and their family members, to not provide them with the most effective traumatic brain injury rehabilitation available.

Respectfully,
Tana Ostrowski, OTA/L, CBIS

Addendum: I feel that it is important to note the following: In 2011 the Community Bridges post acute brain injury rehabilitation program of the Rehabilitation Institute of Montana applied for and received a contract with the VA. At that time, the Bridges program had three components to the program, Residential, Day Treatment and traditional Outpatient BI rehabilitation. The contract was part of a pilot program with the VA and was awarded based on the Bridges program's continuum of care. In the Residential program, an individual with TBI reside in apartments

within a community setting. The residence is staffed and in addition to traditional therapies individuals learn how to become skilled at implementing their compensatory strategies post TBI in real life situations. All aspects of recovery are addressed including behavior regulation. As of 2013 no referrals had been received from the VA. In late 2013 the Residential program was closed, limiting access to this highly successful rehabilitation environment.

An additional concern is the funding cuts to the Yellow Ribbon program. The Governor's TBI Advisory Council was success in obtaining two $50,000 one time funding during the last legislative session, in effort to provide direct outreach and training to rural Montanan's with an emphasis on Veterans and their family members. For months the Council committee worked in collaboration with a member of the National Guard, developed a plan to divide Montana into 10 geographical regions. The plan includes but was not limited to travel to the designated locations to provide education related to the long term effects of TBI, but most importantly provide training to participants to better manage difficult issues that may persist post TBI. Providing family members, Veterans and when needed, care providers, (most often family members and/or spouses), with tools that they can effectively implement on a day to day basis on extremely important. This would have been at no cost to Veterans and their families. I believe that having education, understanding why one is experiencing what they are experiencing and how it impacts their goals and IADLs is fundamentally important for successful management of persistent post TBI symptoms. I also believe that these tools could have a direct impact on reducing the number of suicides among our returning Veterans. It was extremely disappointing when the DoD cut the funding to the Yellow Ribbon program. The Council committee will follow through with outreach, education and training. It is important to note however that without the direct involvement of the VA, National Guard or other direct Service organization participation from Veteran's and their family members and/or care providers will be significantly reduced.

STATEMENT OF CONGRESSWOMA KYRSTEN SINEMA

Thank you Chairman Coffman and Ranking Member Kirkpatrick for allowing me to participate today and for holding this hearing in Arizona.

Chairman Coffman, thank you for coming to our state. We have a proud military tradition here and this issue is very important to us.

Congresswoman Kirkpatrick, you are a great champion for Arizona's veterans and I am glad you brought the Veterans Affairs Committee to Arizona to hear directly from our veterans.

Thank you for holding a hearing on this important topic: Veterans' access to mental health care and traumatic brain injury services.

Finally, thank you to our panelists. Thank you for your service to our country, your sacrifice and for your advocacy for our nation's veterans.

Our state has a proud history of military service and it is critical that our returning veterans have access to appropriate care.

Traumatic brain injury and mental health wounds are the signature wounds of the wars in Afghanistan and Iraq, but previous generations of veterans also have these wounds.

Ensuring access to care is critical, but while resources and attention are now more focused, too many of our veterans our not getting the support they need.

Tragically, 22 veterans lose their lives to suicide every day. This is unacceptable.

I am also disturbed and concerned by the allegations at the Phoenix VA Medical Center that delays in care may have caused the deaths of Arizona veterans. We need to get to the bottom of this and hold accountable those responsible.

This battle cannot be one that is fought by our veterans alone, or by their families or by the VA.

We have to work together as a community and as a country to end this tragedy.

No veteran should feel they have no place to turn and no family should lose their loved one after he or she returns home.

Again, thank you Chairman Coffman and Ranking Member Kirkpatrick for holding this hearing and for your leadership.

And thank you to our panelists for sharing your very personal stories and for working to help other veterans and military families.

REP. RON BARBER (D–AZ–02)

I am sorry that I cannot be with you. I am in Yuma today for the dedication of the John Roll United States Courthouse.

Our nation owes each of our veterans a debt greater than gratitude. I will continue working in Congress with my colleagues, like Congresswomen Kirkpatrick and Congressman Coffman, to ensure that each of our veterans and their families receive the care, the benefits and the opportunities they have earned and deserve.

We need to do all we can as a Congress, a community and a country to guarantee care for those who've served and sacrificed for our nation.

Thank you for coming to Southern Arizona to explore the critical issues of mental health care and traumatic brain injury services for our veterans.